



February 9, 2007

SENATE BILL No. 503

DIGEST OF SB 503 (Updated February 7, 2007 6:12 pm - DI 104)

Citations Affected: IC 4-22; IC 12-7; IC 12-15; IC 12-16; IC 27-8; noncode.

Synopsis: Healthier Indiana insurance program. Establishes the healthier Indiana insurance program and the healthier Indiana insurance program fund. Makes funding changes to the hospital care for the indigent program, the municipal disproportionate share program, and the Medicaid indigent care trust fund. Requires the Indiana comprehensive health insurance association to provide, and referred program participants to participate in, medical management services. Requires the office of Medicaid policy and planning to apply to the United States Department of Health and Human Services for: (1) a demonstration waiver to develop and implement the healthier Indiana insurance program to cover certain individuals; and (2) an amendment to the state Medicaid plan to cover pregnancy related services for pregnant women whose annual household income does not exceed 200% of the federal income poverty level.

Effective: Upon passage; July 1, 2007.

**Miller, Simpson, Becker, Errington,
Sipes, Rogers**

January 23, 2007, read first time and referred to Committee on Health and Provider Services.

February 8, 2007, amended, reported favorably — Do Pass; reassigned to Committee on Appropriations.

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SB 503—LS 7776/DI 104+



February 9, 2007

First Regular Session 115th General Assembly (2007)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2006 Regular Session of the General Assembly.

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SENATE BILL No. 503

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

- 1 SECTION 1. IC 4-22-2-37.1, AS AMENDED BY P.L.47-2006,
2 SECTION 2, AS AMENDED BY P.L.91-2006, SECTION 2, AND AS
3 AMENDED BY P.L.123-2006, SECTION 12, IS CORRECTED AND
4 AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:
5 Sec. 37.1. (a) This section applies to a rulemaking action resulting in
6 any of the following rules:
7 (1) An order adopted by the commissioner of the Indiana
8 department of transportation under IC 9-20-1-3(d) or
9 IC 9-21-4-7(a) and designated by the commissioner as an
10 emergency rule.
11 (2) An action taken by the director of the department of natural
12 resources under IC 14-22-2-6(d) or IC 14-22-6-13.
13 (3) An emergency temporary standard adopted by the
14 occupational safety standards commission under
15 IC 22-8-1.1-16.1.
16 (4) An emergency rule adopted by the solid waste management
17 board under IC 13-22-2-3 and classifying a waste as hazardous.

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- 1 (5) A rule, other than a rule described in subdivision (6), adopted
- 2 by the department of financial institutions under IC 24-4.5-6-107
- 3 and declared necessary to meet an emergency.
- 4 (6) A rule required under IC 24-4.5-1-106 that is adopted by the
- 5 department of financial institutions and declared necessary to
- 6 meet an emergency under IC 24-4.5-6-107.
- 7 (7) A rule adopted by the Indiana utility regulatory commission to
- 8 address an emergency under IC 8-1-2-113.
- 9 (8) An emergency rule adopted by the state lottery commission
- 10 under IC 4-30-3-9.
- 11 (9) A rule adopted under IC 16-19-3-5 that the executive board of
- 12 the state department of health declares is necessary to meet an
- 13 emergency.
- 14 (10) An emergency rule adopted by the Indiana finance authority
- 15 under IC 8-21-12.
- 16 (11) An emergency rule adopted by the insurance commissioner
- 17 under IC 27-1-23-7.
- 18 (12) An emergency rule adopted by the Indiana horse racing
- 19 commission under IC 4-31-3-9.
- 20 (13) An emergency rule adopted by the air pollution control
- 21 board, the solid waste management board, or the water pollution
- 22 control board under IC 13-15-4-10(4) or to comply with a
- 23 deadline required by federal law, provided:
- 24 (A) the variance procedures are included in the rules; and
- 25 (B) permits or licenses granted during the period the
- 26 emergency rule is in effect are reviewed after the emergency
- 27 rule expires.
- 28 (14) An emergency rule adopted by the Indiana election
- 29 commission under IC 3-6-4.1-14.
- 30 (15) An emergency rule adopted by the department of natural
- 31 resources under IC 14-10-2-5.
- 32 (16) An emergency rule adopted by the Indiana gaming
- 33 commission under *IC 4-32.2-3-3(b)*, IC 4-33-4-2, IC 4-33-4-3, or
- 34 IC 4-33-4-14.
- 35 (17) An emergency rule adopted by the alcohol and tobacco
- 36 commission under IC 7.1-3-17.5, IC 7.1-3-17.7, or
- 37 IC 7.1-3-20-24.4.
- 38 (18) An emergency rule adopted by the department of financial
- 39 institutions under IC 28-15-11.
- 40 (19) An emergency rule adopted by the office of the secretary of
- 41 family and social services under IC 12-8-1-12.
- 42 (20) An emergency rule adopted by the office of the children's

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- 1 health insurance program under IC 12-17.6-2-11.
- 2 (21) An emergency rule adopted by the office of Medicaid policy
- 3 and planning under IC 12-15-41-15 **or IC 12-15-44-16.**
- 4 (22) An emergency rule adopted by the Indiana state board of
- 5 animal health under IC 15-2.1-18-21.
- 6 (23) An emergency rule adopted by the board of directors of the
- 7 Indiana education savings authority under IC 21-9-4-7.
- 8 (24) An emergency rule adopted by the Indiana board of tax
- 9 review under IC 6-1.1-4-34 **(repealed).**
- 10 (25) An emergency rule adopted by the department of local
- 11 government finance under IC 6-1.1-4-33 **(repealed).**
- 12 (26) An emergency rule adopted by the boiler and pressure vessel
- 13 rules board under IC 22-13-2-8(c).
- 14 (27) An emergency rule adopted by the Indiana board of tax
- 15 review under IC 6-1.1-4-37(l) **(repealed)** or an emergency rule
- 16 adopted by the department of local government finance under
- 17 IC 6-1.1-4-36(j) **(repealed)** or IC 6-1.1-22.5-20.
- 18 (28) An emergency rule adopted by the board of the Indiana
- 19 economic development corporation under IC 5-28-5-8.
- 20 (29) A rule adopted by the department of financial institutions
- 21 under IC 34-55-10-2.5.
- 22 (30) *A rule adopted by the Indiana finance authority:*
- 23 *(A) under IC 8-15.5-7 approving user fees (as defined in*
- 24 *IC 8-15.5-2-10) provided for in a public-private agreement*
- 25 *under IC 8-15.5;*
- 26 *(B) under IC 8-15-2-17.2(a)(10):*
- 27 *(i) establishing enforcement procedures; and*
- 28 *(ii) making assessments for failure to pay required tolls;*
- 29 *(C) under IC 8-15-2-14(a)(3) authorizing the use of and*
- 30 *establishing procedures for the implementation of the*
- 31 *collection of user fees by electronic or other nonmanual*
- 32 *means; or*
- 33 *(D) to make other changes to existing rules related to a toll*
- 34 *road project to accommodate the provisions of a*
- 35 *public-private agreement under IC 8-15.5.*
- 36 (b) The following do not apply to rules described in subsection (a):
- 37 (1) Sections 24 through 36 of this chapter.
- 38 (2) IC 13-14-9.
- 39 (c) After a rule described in subsection (a) has been adopted by the
- 40 agency, the agency shall submit the rule to the publisher for the
- 41 assignment of a document control number. The agency shall submit the
- 42 rule in the form required by section 20 of this chapter and with the

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1 documents required by section 21 of this chapter. The publisher shall
2 determine the *number of copies format* of the rule and other documents
3 to be submitted under this subsection.

4 (d) After the document control number has been assigned, the
5 agency shall submit the rule to the *secretary of state publisher* for
6 filing. The agency shall submit the rule in the form required by section
7 20 of this chapter and with the documents required by section 21 of this
8 chapter. The *secretary of state publisher* shall determine the *number*
9 *of copies format* of the rule and other documents to be submitted under
10 this subsection.

11 (e) Subject to section 39 of this chapter, the *secretary of state*
12 *publisher* shall:

- 13 (1) accept the rule for filing; and
- 14 (2) *file stamp and indicate electronically record* the date and time
15 that the rule is accepted. *on every duplicate original copy*
16 *submitted.*

17 (f) A rule described in subsection (a) takes effect on the latest of the
18 following dates:

- 19 (1) The effective date of the statute delegating authority to the
20 agency to adopt the rule.
- 21 (2) The date and time that the rule is accepted for filing under
22 subsection (e).
- 23 (3) The effective date stated by the adopting agency in the rule.
- 24 (4) The date of compliance with every requirement established by
25 law as a prerequisite to the adoption or effectiveness of the rule.

26 (g) Subject to subsection (h), IC 14-10-2-5, IC 14-22-2-6,
27 IC 22-8-1.1-16.1, and IC 22-13-2-8(c), and except as provided in
28 subsections (j), ~~and~~ (k), and (l), a rule adopted under this section
29 expires not later than ninety (90) days after the rule is accepted for
30 filing under subsection (e). Except for a rule adopted under subsection
31 (a)(13), (a)(24), (a)(25), or (a)(27), the rule may be extended by
32 adopting another rule under this section, but only for one (1) extension
33 period. The extension period for a rule adopted under subsection
34 (a)(28) may not exceed the period for which the original rule was in
35 effect. A rule adopted under subsection (a)(13) may be extended for
36 two (2) extension periods. Subject to subsection (j), a rule adopted
37 under subsection (a)(24), (a)(25), or (a)(27) may be extended for an
38 unlimited number of extension periods. Except for a rule adopted under
39 subsection (a)(13), for a rule adopted under this section to be effective
40 after one (1) extension period, the rule must be adopted under:

- 41 (1) sections 24 through 36 of this chapter; or
- 42 (2) IC 13-14-9;

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1 as applicable.

2 (h) A rule described in subsection (a)(6), (a)(8), (a)(12), or (a)(29)

3 expires on the earlier of the following dates:

4 (1) The expiration date stated by the adopting agency in the rule.

5 (2) The date that the rule is amended or repealed by a later rule

6 adopted under sections 24 through 36 of this chapter or this

7 section.

8 (i) This section may not be used to readopt a rule under IC 4-22-2.5.

9 (j) A rule described in subsection (a)(24) or (a)(25) expires not later

10 than January 1, 2006.

11 (k) A rule described in subsection (a)(28) expires on the expiration

12 date stated by the board of the Indiana economic development

13 corporation in the rule.

14 (l) *A rule described in subsection (a)(30) expires on the expiration*

15 *date stated by the Indiana finance authority in the rule.*

16 SECTION 2. IC 12-7-2-52.5 IS ADDED TO THE INDIANA CODE

17 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY

18 1, 2007]: **Sec. 52.5. "Custodial parent", for purposes of**

19 **IC 12-15-44, has the meaning set forth in IC 12-15-44-1.**

20 SECTION 3. IC 12-7-2-144.3 IS ADDED TO THE INDIANA

21 CODE AS A NEW SECTION TO READ AS FOLLOWS

22 [EFFECTIVE JULY 1, 2007]: **Sec. 144.3. "Preventative care**

23 **services", for purposes of IC 12-15-44, has the meaning set forth in**

24 **IC 12-15-44-2.**

25 SECTION 4. IC 12-7-2-146 IS AMENDED TO READ AS

26 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 146. "Program" refers

27 to the following:

28 (1) For purposes of IC 12-10-7, the adult guardianship services

29 program established by IC 12-10-7-5.

30 (2) For purposes of IC 12-10-10, the meaning set forth in

31 IC 12-10-10-5.

32 (3) For purposes of IC 12-17.6, the meaning set forth in

33 IC 12-17.6-1-5.

34 **(4) For purposes of IC 12-15-44, the meaning set forth in**

35 **IC 12-15-44-3.**

36 SECTION 5. IC 12-15-15-1.1 IS AMENDED TO READ AS

37 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.1. (a) This section

38 applies to a hospital that is:

39 (1) licensed under IC 16-21; and

40 (2) established and operated under IC 16-22-2, IC 16-22-8, or

41 IC 16-23.

42 (b) For a state fiscal year ending after June 30, 2003, in addition to

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1 reimbursement received under section 1 of this chapter, a hospital is
2 entitled to reimbursement in an amount calculated as follows:

3 STEP ONE: The office shall identify the aggregate inpatient
4 hospital services, reimbursable under this article and under the
5 state Medicaid plan, that were provided during the state fiscal
6 year by hospitals established and operated under IC 16-22-2,
7 IC 16-22-8, or IC 16-23.

8 STEP TWO: For the aggregate inpatient hospital services
9 identified under STEP ONE, the office shall calculate the
10 aggregate payments made under this article and under the state
11 Medicaid plan to hospitals established and operated under
12 IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under
13 IC 12-15-16, IC 12-15-17, and IC 12-15-19.

14 STEP THREE: The office shall calculate a reasonable estimate of
15 the amount that would have been paid in the aggregate by the
16 office for the inpatient hospital services described in STEP ONE
17 under Medicare payment principles.

18 STEP FOUR: Subtract the amount calculated under STEP TWO
19 from the amount calculated under STEP THREE.

20 STEP FIVE: Subject to subsection (g), from the amount
21 calculated under STEP FOUR, allocate to a hospital established
22 and operated under IC 16-22-8 an amount equal to one hundred
23 percent (100%) of the difference between:

24 (A) the total cost for the hospital's provision of inpatient
25 services covered under this article for the hospital's fiscal year
26 ending during the state fiscal year; and

27 (B) the total payment to the hospital for its provision of
28 inpatient services covered under this article for the hospital's
29 fiscal year ending during the state fiscal year, excluding
30 payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

31 STEP SIX: Subtract the amount calculated under STEP FIVE
32 from the amount calculated under STEP FOUR.

33 STEP SEVEN: Distribute an amount equal to the amount
34 calculated under STEP SIX to the eligible hospitals established
35 and operated under IC 16-22-2 or IC 16-23 described in
36 subsection (c) in proportion to each hospital's Medicaid ~~shortfall~~
37 **supplemental payment** as defined in subsection (f).

38 (c) Subject to subsection (e), reimbursement for a state fiscal year
39 under this section consists of payments made after the close of each
40 state fiscal year. ~~Payment for a state fiscal year ending after June 30,~~
41 ~~2003, shall be made before December 31 following the state fiscal~~
42 ~~year's end.~~ A hospital is not eligible for a payment described in this

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1 subsection unless an intergovernmental transfer is made under
2 subsection (d).

3 (d) Subject to subsection (e), a hospital may make an
4 intergovernmental transfer under this subsection, or an
5 intergovernmental transfer may be made on behalf of the hospital, after
6 the close of each state fiscal year. An intergovernmental transfer under
7 this subsection must be made to the Medicaid indigent care trust fund
8 in an amount equal to a percentage, as determined by the office, of the
9 amount to be distributed to the hospital under ~~STEP SEVEN~~ of
10 subsection (b). ~~In determining the percentage, the office shall apply the~~
11 ~~same percentage of not more than eighty-five percent (85%) to all~~
12 ~~hospitals eligible for reimbursement under STEP SEVEN of subsection~~
13 ~~(b):~~ **this section.** The office shall use the intergovernmental transfer to
14 fund payments made under this section. ~~and as otherwise provided~~
15 ~~under IC 12-15-20-2(8):~~

16 (e) A hospital making an intergovernmental transfer under
17 ~~subsection (d)~~ **this section** may appeal under IC 4-21.5 the amount
18 determined by the office to be paid the hospital under ~~STEP SEVEN~~ of
19 subsection (b). The periods described in subsections (c) and (d) for the
20 hospital to make an intergovernmental transfer are tolled pending the
21 administrative appeal and any judicial review initiated by the hospital
22 under IC 4-21.5. The distribution to other hospitals under ~~STEP~~
23 ~~SEVEN~~ of subsection (b) may not be delayed due to an administrative
24 appeal or judicial review instituted by a hospital under this subsection.
25 If necessary, the office may make a partial distribution to the other
26 eligible hospitals under ~~STEP SEVEN~~ of subsection (b) pending the
27 completion of a hospital's administrative appeal or judicial review, at
28 which time the remaining portion of the payments due to the eligible
29 hospitals shall be made. A partial distribution may be based upon
30 estimates and trends calculated by the office.

31 (f) For purposes of this section:

32 (1) the Medicaid ~~shortfall~~ **supplemental payment** of a hospital
33 established and operated under IC 16-22-2 or IC 16-23 is
34 calculated as follows:

35 STEP ONE: The office shall identify the inpatient hospital
36 services, reimbursable under this article and under the state
37 Medicaid plan, that were provided during the state fiscal year
38 by the hospital.

39 STEP TWO: For the inpatient hospital services identified
40 under STEP ONE, the office shall calculate the payments
41 made under this article and under the state Medicaid plan to
42 the hospital, excluding payments under IC 12-15-16,

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1 IC 12-15-17, and IC 12-15-19.

2 STEP THREE: The office shall calculate a reasonable estimate

3 of the amount that would have been paid by the office for the

4 inpatient hospital services described in STEP ONE under

5 Medicare payment principles; and

6 (2) a hospital's Medicaid ~~shortfall~~ **supplemental payment** is

7 equal to the amount by which the amount calculated in STEP

8 THREE of subdivision (1) is greater than the amount calculated

9 in STEP TWO of subdivision (1).

10 (g) The actual distribution of the amount calculated under STEP

11 FIVE of subsection (b) to a hospital established and operated under

12 IC 16-22-8 shall be made under the terms and conditions provided for

13 the hospital in the state plan for medical assistance. Payment to a

14 hospital under STEP FIVE of subsection (b) is not a condition

15 precedent to the tender of payments to hospitals under STEP SEVEN

16 of subsection (b).

17 SECTION 6. IC 12-15-15-1.3 IS AMENDED TO READ AS

18 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.3. (a) This section

19 applies to a hospital that is:

20 (1) licensed under IC 16-21; and

21 (2) established and operated under IC 16-22-2, IC 16-22-8, or

22 IC 16-23.

23 (b) For a state fiscal year ending after June 30, 2003, in addition to

24 reimbursement received under section 1 of this chapter, a hospital is

25 entitled to reimbursement in an amount calculated as follows:

26 STEP ONE: The office shall identify the aggregate outpatient

27 hospital services, reimbursable under this article and under the

28 state Medicaid plan, that were provided during the state fiscal

29 year by hospitals established and operated under IC 16-22-2,

30 IC 16-22-8, or IC 16-23.

31 STEP TWO: For the aggregate outpatient hospital services

32 identified under STEP ONE, the office shall calculate the

33 aggregate payments made under this article and under the state

34 Medicaid plan to hospitals established and operated under

35 IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under

36 IC 12-15-16, IC 12-15-17, and IC 12-15-19.

37 STEP THREE: The office shall calculate a reasonable estimate of

38 the amount that would have been paid in the aggregate by the

39 office under Medicare payment principles for the outpatient

40 hospital services described in STEP ONE.

41 STEP FOUR: Subtract the amount calculated under STEP TWO

42 from the amount calculated under STEP THREE.

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1 STEP FIVE: Subject to subsection (g), from the amount
2 calculated under STEP FOUR, allocate to a hospital established
3 and operated under IC 16-22-8 an amount equal to one hundred
4 percent (100%) of the difference between:

5 (A) the total cost for the hospital's provision of outpatient
6 services covered under this article for the hospital's fiscal year
7 ending during the state fiscal year; and

8 (B) the total payment to the hospital for its provision of
9 outpatient services covered under this article for the hospital's
10 fiscal year ending during the state fiscal year, excluding
11 payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

12 STEP SIX: Subtract the amount calculated under STEP FIVE
13 from the amount calculated under STEP FOUR.

14 STEP SEVEN: Distribute an amount equal to the amount
15 calculated under STEP SIX to the eligible hospitals established
16 and operated under IC 16-22-2 or IC 16-23 described in
17 subsection (c) in proportion to each hospital's Medicaid ~~shortfall~~
18 **supplemental payment** as defined in subsection (f).

19 (c) ~~Subject to subsection (e), the reimbursement for a state fiscal~~
20 ~~year under this section consists of payments made before December 31~~
21 ~~following the end of the state fiscal year.~~ A hospital is not eligible for
22 a payment described in this subsection unless an intergovernmental
23 transfer is made ~~under subsection (d):~~ **by the hospital or on behalf of**
24 **the hospital.**

25 (d) Subject to subsection (e), a hospital may make an
26 intergovernmental transfer under this subsection, or an
27 intergovernmental transfer may be made on behalf of the hospital, after
28 the close of each state fiscal year. An intergovernmental transfer under
29 this subsection must be made to the Medicaid indigent care trust fund
30 in an amount equal to a percentage, as determined by the office, of the
31 amount to be distributed to the hospital under ~~STEP SEVEN~~ of
32 subsection (b). ~~In determining the percentage, the office shall apply the~~
33 ~~same percentage of not more than eighty-five percent (85%) to all~~
34 ~~hospitals eligible for reimbursement under STEP SEVEN of subsection~~
35 ~~(b):~~ The office shall use the intergovernmental transfer to fund
36 payments made under this section. ~~and as otherwise provided under~~
37 ~~IC 12-15-20-2(8).~~

38 (e) A hospital making an intergovernmental transfer under
39 ~~subsection (d)~~ **this section** may appeal under IC 4-21.5 the amount
40 determined by the office to be paid by the hospital under ~~STEP SEVEN~~
41 ~~of subsection (b).~~ The periods described in subsections (c) and (d) for
42 the hospital to make an intergovernmental transfer are tolled pending

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1 the administrative appeal and any judicial review initiated by the
2 hospital under IC 4-21.5. The distribution to other hospitals under
3 ~~STEP SEVEN~~ of subsection (b) may not be delayed due to an
4 administrative appeal or judicial review instituted by a hospital under
5 this subsection. If necessary, the office may make a partial distribution
6 to the other eligible hospitals under ~~STEP SEVEN~~ of subsection (b)
7 pending the completion of a hospital's administrative appeal or judicial
8 review, at which time the remaining portion of the payments due to the
9 eligible hospitals must be made. A partial distribution may be
10 calculated by the office based upon estimates and trends.

11 (f) For purposes of this section:

12 (1) the Medicaid ~~shortfall~~ **supplemental payment** of a hospital
13 established and operated under IC 16-22-2 or IC 16-23 is
14 calculated as follows:

15 STEP ONE: The office shall identify the outpatient hospital
16 services, reimbursable under this article and under the state
17 Medicaid plan, that were provided during the state fiscal year
18 by the hospital.

19 STEP TWO: For the outpatient hospital services identified
20 under STEP ONE, the office shall calculate the payments
21 made under this article and under the state Medicaid plan to
22 the hospital, excluding payments under IC 12-15-16,
23 IC 12-15-17, and IC 12-15-19.

24 STEP THREE: The office shall calculate a reasonable estimate
25 of the amount that would have been paid by the office for the
26 outpatient hospital services described in STEP ONE under
27 Medicare payment principles; and

28 (2) a hospital's Medicaid ~~shortfall~~ **supplemental payment** is
29 equal to the amount by which the amount calculated in STEP
30 THREE of subdivision (1) is greater than the amount calculated
31 in STEP TWO of subdivision (1).

32 (g) The actual distribution of the amount calculated under STEP
33 FIVE of subsection (b) to a hospital established and operated under
34 IC 16-22-8 shall be made under the terms and conditions provided for
35 the hospital in the state plan for medical assistance. Payment to a
36 hospital under STEP FIVE of subsection (b) is not a condition
37 precedent to the tender of payments to hospitals under STEP SEVEN
38 of subsection (b).

39 SECTION 7. IC 12-15-15-1.5 IS AMENDED TO READ AS
40 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.5. (a) This section
41 applies to a hospital that:

42 (1) is licensed under IC 16-21;

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1 (2) is not a unit of state or local government; and
 2 (3) is not owned or operated by a unit of state or local
 3 government.
 4 (b) For a state fiscal year ending after June 30, 2003, **and before**
 5 **July 1, 2005**, in addition to reimbursement received under section 1 of
 6 this chapter, a hospital eligible under this section is entitled to
 7 reimbursement in an amount calculated as follows:
 8 STEP ONE: The office shall identify the total inpatient hospital
 9 services and the total outpatient hospital services, reimbursable
 10 under this article and under the state Medicaid plan, that were
 11 provided during the state fiscal year by the hospitals described in
 12 subsection (a).
 13 STEP TWO: For the total inpatient hospital services and the total
 14 outpatient hospital services identified under STEP ONE, the
 15 office shall calculate the aggregate payments made under this
 16 article and under the state Medicaid plan to hospitals described in
 17 subsection (a), excluding payments under IC 12-15-16,
 18 IC 12-15-17, and IC 12-15-19.
 19 STEP THREE: The office shall calculate a reasonable estimate of
 20 the amount that would have been paid in the aggregate by the
 21 office for the inpatient hospital services and the outpatient
 22 hospital services identified in STEP ONE under Medicare
 23 payment principles.
 24 STEP FOUR: Subtract the amount calculated under STEP TWO
 25 from the amount calculated under STEP THREE.
 26 STEP FIVE: Distribute an amount equal to the amount calculated
 27 under STEP FOUR to the eligible hospitals described in
 28 subsection (a) as follows:
 29 (A) Subject to the availability of funds under
 30 IC 12-15-20-2(8)(D) to serve as the non-federal share of such
 31 payment, the first ten million dollars (\$10,000,000) of the
 32 amount calculated under STEP FOUR for a state fiscal year
 33 shall be paid to a hospital described in subsection (a) that has
 34 more than seventy thousand (70,000) Medicaid inpatient days.
 35 (B) Following the payment to the hospital under clause (A)
 36 and subject to the availability of funds under
 37 IC 12-15-20-2(8)(D) to serve as the non-federal share of such
 38 payments, the remaining amount calculated under STEP
 39 FOUR for a state fiscal year shall be paid to all hospitals
 40 described in subsection (a). The payments shall be made on a
 41 pro rata basis based on the hospitals' Medicaid inpatient days
 42 or other payment methodology approved by the Centers for

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Medicare and Medicaid Services.
(C) Subject to IC 12-15-20.7, in the event the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) and (B), the remaining amount may be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause only if the non-federal share of the hospital's payment is provided by or on behalf of the hospital. The remaining amount shall be paid to those eligible hospitals on a pro rata basis in relation to all hospitals eligible under this clause based on the hospitals' Medicaid inpatient days or other payment methodology approved by the Centers for Medicare and Medicaid Services.
(D) For purposes of the clauses (A), (B) and (C), a hospital's Medicaid inpatient days are based on the Medicaid inpatient days allowed for the hospital by the office for purposes of the office's most recent determination of eligibility for the Medicaid disproportionate payment program under IC 12-15-16.

(c) Reimbursement for a state fiscal year under this section consists of payments made after the close of each state fiscal year. Payment for a state fiscal year ending after June 30, 2003, shall be made before December 31 following the end of the state fiscal year.

(c) For state fiscal years ending after July 1, 2005, in addition to reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by a hospital described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified under STEP ONE, the office shall calculate the total payments made under this article and under the state Medicaid plan to a hospital described in subsection (a), excluding payments made under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the total amount that would have been paid by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE under Medicare

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payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) Subject to the availability of funds under IC 12-15-20-2(7) to serve as the non-federal share of the payments, the amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis based on the hospitals' Medicaid inpatient days or, if the federal Centers for Medicare and Medicaid Services do not approve that methodology, another payment methodology approved by the federal Centers for Medicare and Medicaid Services. For purposes of this clause, a hospital's Medicaid inpatient days are the hospital's in-state Medicaid paid claims and Medicaid managed care days for the state fiscal year referenced in STEP ONE, as determined by the office.

(B) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clause (A), the remaining amount shall be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause only if the hospital:

- (i) has less than seventy thousand (70,000) Medicaid inpatient days annually;**
- (ii) was eligible for disproportionate share hospital payments under IC 12-15-19-2.1 for the state fiscal year ending June 30, 1998, or the hospital met the office's Medicaid disproportionate share payment criteria for payment under IC 12-15-19-2.1 based upon state fiscal year 1998 data and received a Medicaid disproportionate share payment for the state fiscal year ending June 30, 2001; and**
- (iii) received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004.**

The amount of a hospital's payment under this clause is subject to the extent that Medicaid indigent care trust funds are available or, if none are available, the

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non-federal share of the hospital's payment is provided by or on behalf of the hospital. The payment to each hospital shall equal the hospital's hospital specific limit provided under 42 U.S.C. 1396r-4 when the payments are combined with any other Medicaid payments made to the hospital. For state fiscal years ending before July 1, 2008, the total payments made under this clause may not exceed a total amount of sixty-eight million dollars (\$68,000,000). For a state fiscal year ending after June 30, 2008, the total payments made under this clause may not exceed a total amount of sixty-eight million dollars (\$68,000,000) plus the annual percentage growth in the state's aggregate Medicaid upper payment limit, as calculated by the office. (C) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) and (B), the remaining amount may be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause if the hospital:

- (i) has less than seventy thousand (70,000) Medicaid inpatient days annually;
- (ii) has received or is eligible to receive Medicaid disproportionate share payments under IC 12-15-19-2.1 for state fiscal years 2002, 2003, 2004, and for each state fiscal year after 2004; and
- (iii) provides, or has provided on the hospital's behalf, the non-federal share of the hospital's payment.

A payment to a hospital under this clause is subject to the availability of non-federal dollars. The payment to each hospital shall not exceed ninety percent (90%) of the hospital's Medicaid shortfall. As used in this clause, Medicaid shortfall is the amount of the hospital's Medicaid costs less the hospital's Medicaid reimbursement and any payments received by the hospital under IC 12-15-15-9 and IC 12-15-15-9.5. For state fiscal years ending before July 1, 2008, the total payments made under this clause may not exceed a total amount of twenty-three million five hundred thousand dollars (\$23,500,000). For a state fiscal year ending after June 30, 2008, the total payments made under this clause may not exceed a total amount of twenty-three million five hundred thousand dollars (\$23,500,000) plus the annual percentage growth in the state's aggregate

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1 **Medicaid upper payment limit, as determined by the office.**
 2 **(D) Subject to IC 12-15-20.7, if the entirety of the amount**
 3 **calculated under STEP FOUR is not distributed following**
 4 **the payments made under clauses (A) through (C), the**
 5 **remaining amount shall be paid to hospitals described in**
 6 **subsection (a) that are eligible under this clause. A hospital**
 7 **is eligible for payment under this clause if the hospital**
 8 **provides, or has provided on the hospital's behalf, the**
 9 **non-federal share of the hospital's payment.**
 10 **(E) As used in clauses (A) through (D), a hospital's**
 11 **Medicaid inpatient days are based on the hospital's**
 12 **Medicaid paid claims and Medicaid managed care days for**
 13 **the current state fiscal year, as determined by the office.**

14 (d) A hospital described in subsection (a) may appeal under
 15 IC 4-21.5 the amount determined by the office to be paid to the hospital
 16 under STEP FIVE of subsection (b) **or subsection (c)**. The distribution
 17 to other hospitals under STEP FIVE of subsection (b) **or subsection (c)**
 18 may not be delayed due to an administrative appeal or judicial review
 19 instituted by a hospital under this subsection. If necessary, the office
 20 may make a partial distribution to the other eligible hospitals under
 21 STEP FIVE of subsection (b) **or subsection (c)** pending the completion
 22 of a hospital's administrative appeal or judicial review, at which time
 23 the remaining portion of the payments due to the eligible hospitals shall
 24 be made. A partial distribution may be based on estimates and trends
 25 calculated by the office.

26 SECTION 8. IC 12-15-15-9 IS AMENDED TO READ AS
 27 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9. (a) For purposes of
 28 this section and IC 12-16-7.5-4.5, a payable claim is attributed to a
 29 county if the payable claim is submitted to the division by a hospital
 30 licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care
 31 provided by the hospital to an individual who qualifies for the hospital
 32 care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2
 33 and:

- 34 (1) who is a resident of the county;
- 35 (2) who is not a resident of the county and for whom the onset of
 36 the medical condition that necessitated the care occurred in the
 37 county; or
- 38 (3) whose residence cannot be determined by the division and for
 39 whom the onset of the medical condition that necessitated the care
 40 occurred in the county.

41 (b) For each state fiscal year ending after June 30, 2003, **and before**
 42 **July 1, 2006**, a hospital licensed under IC 16-21-2 that submits to the

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1 division during the state fiscal year a payable claim under IC 12-16-7.5
2 is entitled to a payment under ~~this section~~: **subsection (c)**.

3 (c) Except as provided in section 9.8 of this chapter and subject to
4 section 9.6 of this chapter, for a state fiscal year, the office shall pay to
5 a hospital referred to in subsection (b) an amount equal to the amount,
6 based on information obtained from the division and the calculations
7 and allocations made under IC 12-16-7.5-4.5, that the office determines
8 for the hospital under STEP SIX of the following STEPS:

9 STEP ONE: Identify:
10 (A) each hospital that submitted to the division one (1) or
11 more payable claims under IC 12-16-7.5 during the state fiscal
12 year; and

13 (B) the county to which each payable claim is attributed.

14 STEP TWO: For each county identified in STEP ONE, identify:

15 (A) each hospital that submitted to the division one (1) or
16 more payable claims under IC 12-16-7.5 attributed to the
17 county during the state fiscal year; and

18 (B) the total amount of all hospital payable claims submitted
19 to the division under IC 12-16-7.5 attributed to the county
20 during the state fiscal year.

21 STEP THREE: For each county identified in STEP ONE, identify
22 the amount of county funds transferred to the Medicaid indigent
23 care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

24 STEP FOUR: For each hospital identified in STEP ONE, with
25 respect to each county identified in STEP ONE, calculate the
26 hospital's percentage share of the county's funds transferred to the
27 Medicaid indigent care trust fund under STEP FOUR of
28 IC 12-16-7.5-4.5(b). Each hospital's percentage share is based on
29 the total amount of the hospital's payable claims submitted to the
30 division under IC 12-16-7.5 attributed to the county during the
31 state fiscal year, calculated as a percentage of the total amount of
32 all hospital payable claims submitted to the division under
33 IC 12-16-7.5 attributed to the county during the state fiscal year.

34 STEP FIVE: Subject to subsection (j), for each hospital identified
35 in STEP ONE, with respect to each county identified in STEP
36 ONE, multiply the hospital's percentage share calculated under
37 STEP FOUR by the amount of the county's funds transferred to
38 the Medicaid indigent care trust fund under STEP FOUR of
39 IC 12-16-7.5-4.5(b).

40 STEP SIX: Determine the sum of all amounts calculated under
41 STEP FIVE for each hospital identified in STEP ONE with
42 respect to each county identified in STEP ONE.

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1 **(d) For state fiscal years beginning after June 30, 2006, a**
2 **hospital that received a payment determined under STEP SIX of**
3 **subsection (c) for the state fiscal year ending June 30, 2006, shall**
4 **be paid in an amount equal to the amount determined for the**
5 **hospital under STEP SIX of subsection (c) for the state fiscal year**
6 **ending June 30, 2006.**

7 ~~(d)~~ **(e)** A hospital's payment under subsection (c) **or (d)** is in the
8 form of a Medicaid ~~add-on~~ **supplemental** payment. The amount of a
9 hospital's ~~add-on~~ **Medicaid supplemental** payment is subject to the
10 availability of funding for the non-federal share of the payment under
11 subsection ~~(e)~~: **(f)**. The office shall make the payments under
12 ~~subsection~~ **subsections (c) and (d)** before December 15 that next
13 succeeds the end of the state fiscal year.

14 ~~(e)~~ **(f)** The non-federal share of a payment to a hospital under
15 subsection (c) **or (d)** is funded from the funds transferred to the
16 Medicaid indigent care trust fund under STEP FOUR of
17 IC 12-16-7.5-4.5(b) of each county to which a payable claim under
18 IC 12-16-7.5 submitted to the division during the state fiscal year by
19 the hospital is attributed.

20 ~~(f)~~ **(g)** The amount of a county's transferred funds available to be
21 used to fund the non-federal share of a payment to a hospital under
22 subsection (c) **or (d)** is an amount that bears the same proportion to the
23 total amount of funds of the county transferred to the Medicaid indigent
24 care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) that the total
25 amount of the hospital's payable claims under IC 12-16-7.5 attributed
26 to the county submitted to the division during the state fiscal year bears
27 to the total amount of all hospital payable claims under IC 12-16-7.5
28 attributed to the county submitted to the division during the state fiscal
29 year.

30 ~~(g)~~ **(h)** Any county's funds identified in subsection ~~(f)~~ **(g)** that
31 remain after the non-federal share of a hospital's payment has been
32 funded are available to serve as the non-federal share of a payment to
33 a hospital under section 9.5 of this chapter.

34 ~~(h)~~ **(i)** For purposes of this section, "payable claim" has the meaning
35 set forth in IC 12-16-7.5-2.5(b)(1).

36 ~~(i)~~ **(j)** For purposes of this section:
37 (1) the amount of a payable claim is an amount equal to the
38 amount the hospital would have received under the state's
39 fee-for-service Medicaid reimbursement principles for the
40 hospital care for which the payable claim is submitted under
41 IC 12-16-7.5 if the individual receiving the hospital care had been
42 a Medicaid enrollee; and

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1 (2) a payable hospital claim under IC 12-16-7.5 includes a
2 payable claim under IC 12-16-7.5 for the hospital's care submitted
3 by an individual or entity other than the hospital, to the extent
4 permitted under the hospital care for the indigent program.

5 (j) (k) The amount calculated under STEP FIVE of subsection (c)
6 for a hospital with respect to a county may not exceed the total amount
7 of the hospital's payable claims attributed to the county during the state
8 fiscal year.

9 SECTION 9. IC 12-15-15-9.5 IS AMENDED TO READ AS
10 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9.5. (a) For purposes
11 of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a
12 county if the payable claim is submitted to the division by a hospital
13 licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care
14 provided by the hospital to an individual who qualifies for the hospital
15 care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2
16 and;

- 17 (1) who is a resident of the county;
- 18 (2) who is not a resident of the county and for whom the onset of
19 the medical condition that necessitated the care occurred in the
20 county; or
- 21 (3) whose residence cannot be determined by the division and for
22 whom the onset of the medical condition that necessitated the care
23 occurred in the county.

24 (b) For each state fiscal year ending after June 30, 2003, **but before**
25 **July 1, 2006**, a hospital licensed under IC 16-21-2:

- 26 (1) that submits to the division during the state fiscal year a
27 payable claim under IC 12-16-7.5; and
- 28 (2) whose payment under section 9(c) of this chapter was less
29 than the total amount of the hospital's payable claims under
30 IC 12-16-7.5 submitted by the hospital to the division during the
31 state fiscal year;

32 is entitled to a payment under ~~this section~~ **subsection (c)**.

33 (c) Except as provided in section 9.8 of this chapter and subject to
34 section 9.6 of this chapter, for a state fiscal year, the office shall pay to
35 a hospital referred to in subsection (b) an amount equal to the amount,
36 based on information obtained from the division and the calculations
37 and allocations made under IC 12-16-7.5-4.5, that the office determines
38 for the hospital under STEP EIGHT of the following STEPS:

39 STEP ONE: Identify each county whose transfer of funds to the
40 Medicaid indigent care trust fund under STEP FOUR of
41 IC 12-16-7.5-4.5(b) for the state fiscal year was less than the total
42 amount of all hospital payable claims attributed to the county and

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1 submitted to the division during the state fiscal year.
 2 STEP TWO: For each county identified in STEP ONE, calculate
 3 the difference between the amount of funds of the county
 4 transferred to the Medicaid indigent care trust fund under STEP
 5 FOUR of IC 12-16-7.5-4.5(b) and the total amount of all hospital
 6 payable claims attributed to the county and submitted to the
 7 division during the state fiscal year.
 8 STEP THREE: Calculate the sum of the amounts calculated for
 9 the counties under STEP TWO.
 10 STEP FOUR: Identify each hospital whose payment under section
 11 9(c) of this chapter was less than the total amount of the hospital's
 12 payable claims under IC 12-16-7.5 submitted by the hospital to
 13 the division during the state fiscal year.
 14 STEP FIVE: Calculate for each hospital identified in STEP FOUR
 15 the difference between the hospital's payment under section 9(c)
 16 of this chapter and the total amount of the hospital's payable
 17 claims under IC 12-16-7.5 submitted by the hospital to the
 18 division during the state fiscal year.
 19 STEP SIX: Calculate the sum of the amounts calculated for each
 20 of the hospitals under STEP FIVE.
 21 STEP SEVEN: For each hospital identified in STEP FOUR,
 22 calculate the hospital's percentage share of the amount calculated
 23 under STEP SIX. Each hospital's percentage share is based on the
 24 amount calculated for the hospital under STEP FIVE calculated
 25 as a percentage of the sum calculated under STEP SIX.
 26 STEP EIGHT: For each hospital identified in STEP FOUR,
 27 multiply the hospital's percentage share calculated under STEP
 28 SEVEN by the sum calculated under STEP THREE. The amount
 29 calculated under this STEP for a hospital may not exceed the
 30 amount by which the hospital's total payable claims under
 31 IC 12-16-7.5 submitted during the state fiscal year exceeded the
 32 amount of the hospital's payment under section 9(c) of this
 33 chapter.
 34 **(d) For state fiscal years beginning after June 30, 2006, a**
 35 **hospital that received a payment determined under STEP EIGHT**
 36 **of subsection (c) for the state fiscal year ending June 30, 2006, will**
 37 **be paid an amount equal to the amount determined for the hospital**
 38 **under STEP EIGHT of subsection (c) for the state fiscal year**
 39 **ending June 30, 2006.**
 40 ~~(d)~~ **(e)** A hospital's payment under subsection (c) **or (d)** is in the
 41 form of a Medicaid ~~add-on~~ **supplemental** payment. The amount of the
 42 hospital's add-on payment is subject to the availability of funding for

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1 the non-federal share of the payment under subsection ~~(c)~~ **(f)**. The
 2 office shall make the payments under subsection (c) **or (d)** before
 3 December 15 that next succeeds the end of the state fiscal year.

4 ~~(c)~~ **(f)** The non-federal share of a payment to a hospital under
 5 subsection (c) **or (d)** is derived from funds transferred to the Medicaid
 6 indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and
 7 not expended under section 9 of this chapter. ~~To the extent possible;~~
 8 ~~the funds shall be derived on a proportional basis from the funds~~
 9 ~~transferred by each county identified in subsection (c); STEP ONE:~~
 10 ~~(1) to which at least one (1) payable claim submitted by the~~
 11 ~~hospital to the division during the state fiscal year is attributed;~~
 12 ~~and~~
 13 ~~(2) whose funds transferred to the Medicaid indigent care trust~~
 14 ~~fund under STEP FOUR of IC 12-16-7.5-4.5(b) were not~~
 15 ~~completely expended under section 9 of this chapter.~~

16 The amount available to be derived from the remaining funds
 17 transferred to the Medicaid indigent care trust fund under STEP FOUR
 18 of IC 12-16-7.5-4.5(b) to serve as the non-federal share of the payment
 19 to a hospital under subsection ~~(c)~~ is an amount that bears the same
 20 proportion to the total amount of funds transferred by all the counties
 21 identified in subsection ~~(c)~~; STEP ONE; that the amount calculated for
 22 the hospital under subsection ~~(c)~~; STEP FIVE; bears to the amount
 23 calculated under subsection ~~(c)~~; STEP SIX.

24 ~~(f)~~ **(g)** Except as provided in subsection ~~(g)~~; **(h)**, the office may not
 25 make a payment under this section until the payments due under
 26 section 9 of this chapter for the state fiscal year have been made.

27 ~~(g)~~ **(h)** If a hospital appeals a decision by the office regarding the
 28 hospital's payment under section 9 of this chapter, the office may make
 29 payments under this section before all payments due under section 9 of
 30 this chapter are made if:
 31 (1) a delay in one (1) or more payments under section 9 of this
 32 chapter resulted from the appeal; and
 33 (2) the office determines that making payments under this section
 34 while the appeal is pending will not unreasonably affect the
 35 interests of hospitals eligible for a payment under this section.

36 ~~(h)~~ **(i)** Any funds transferred to the Medicaid indigent care trust fund
 37 under STEP FOUR of IC 12-16-7.5-4.5(b) remaining after payments
 38 are made under this section shall be used as provided in
 39 ~~IC 12-15-20-2(8)(D)~~; **IC 12-15-20-2(8)**.

40 ~~(i)~~ **(j)** For purposes of this section:
 41 (1) "payable claim" has the meaning set forth in
 42 IC 12-16-7.5-2.5(b);

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- 1 (2) the amount of a payable claim is an amount equal to the
- 2 amount the hospital would have received under the state's
- 3 fee-for-service Medicaid reimbursement principles for the
- 4 hospital care for which the payable claim is submitted under
- 5 IC 12-16-7.5 if the individual receiving the hospital care had been
- 6 a Medicaid enrollee; and
- 7 (3) a payable hospital claim under IC 12-16-7.5 includes a
- 8 payable claim under IC 12-16-7.5 for the hospital's care submitted
- 9 by an individual or entity other than the hospital, to the extent
- 10 permitted under the hospital care for the indigent program.

11 SECTION 10. IC 12-15-15-9.8 IS AMENDED TO READ AS
 12 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9.8. (a) This section
 13 applies only if the office determines, based on information received
 14 from the United States Centers for Medicare and Medicaid Services,
 15 that a state Medicaid plan amendment implementing the payment
 16 methodology in:

- 17 (1) section 9(c) of this chapter; or
 - 18 (2) section 9.5(c) of this chapter;
- 19 will not be approved by the United States Centers for Medicare and
 20 Medicaid Services.

21 (b) The office may amend the state Medicaid plan to implement an
 22 alternative payment methodology. to the payment methodology under
 23 section 9 of this chapter. The alternative payment methodology must
 24 provide each hospital that would have received a payment under
 25 section 9(c) of this chapter during a state fiscal year with an amount for
 26 the state fiscal year that is as equal as possible to the amount each
 27 hospital would have received under the payment methodology under
 28 section 9(c) of this chapter. A payment methodology implemented
 29 under this subsection is in place of the payment methodology under
 30 section 9(c) of this chapter.

31 (c) The office may amend the state Medicaid plan to implement an
 32 alternative payment methodology to the payment methodology under
 33 section 9.5 of this chapter. The alternative payment methodology must
 34 provide each hospital that would have received a payment under
 35 section 9.5(c) of this chapter during a state fiscal year with an amount
 36 for the state fiscal year that is as equal as possible to the amount each
 37 hospital would have received under the payment methodology under
 38 section 9.5(c) of this chapter. A payment methodology implemented
 39 under this subsection is in place of the payment methodology under
 40 section 9.5(c) of this chapter.

41 SECTION 11. IC 12-15-15-10 IS AMENDED TO READ AS
 42 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 10. (a) This section

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1 applies to a hospital that:

2 (1) is licensed under IC 16-21; and

3 (2) qualifies as a provider under **IC 12-15-16, IC 12-15-17, or**

4 **IC 12-15-19 of** the Medicaid disproportionate share provider

5 program.

6 (b) The office may, after consulting with affected providers, do one

7 (1) or more of the following:

8 ~~(1) Expand the payment program established under section 1.1(b)~~

9 ~~of this chapter to include all hospitals described in subsection (a):~~

10 ~~(2) (1) Establish a nominal charge hospital payment program.~~

11 ~~(3) (2) Establish any other permissible payment program.~~

12 (c) A program expanded or established under this section is subject

13 to the availability of:

14 (1) intergovernmental transfers; ~~or~~

15 (2) funds certified as being eligible for federal financial

16 participation; **or**

17 **(3) other permissible sources of non-federal share dollars.**

18 (d) The office may not implement a program under this section until

19 the federal Centers for Medicare and Medicaid Services approves the

20 provisions regarding the program in the amended state plan for medical

21 assistance.

22 (e) The office may determine not to continue to implement a

23 program established under this section if federal financial participation

24 is not available.

25 SECTION 12. IC 12-15-19-2.1 IS AMENDED TO READ AS

26 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2.1. (a) For each state

27 fiscal year ending on or after June 30, 2000, the office shall develop a

28 disproportionate share payment methodology that ensures that each

29 hospital qualifying for disproportionate share payments under

30 IC 12-15-16-1(a) timely receives total disproportionate share payments

31 that do not exceed the hospital's hospital specific limit provided under

32 42 U.S.C. 1396r-4(g). The payment methodology as developed by the

33 office must:

34 (1) maximize disproportionate share hospital payments to

35 qualifying hospitals to the extent practicable;

36 (2) take into account the situation of those qualifying hospitals

37 that have historically qualified for Medicaid disproportionate

38 share payments; and

39 (3) ensure that payments net of intergovernmental transfers made

40 by or on behalf of qualifying hospitals are equitable.

41 (b) Total disproportionate share payments to a hospital under this

42 chapter shall not exceed the hospital specific limit provided under 42

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1 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year
2 shall be determined by the office taking into account data provided by
3 each hospital that is considered reliable by the office based on a system
4 of periodic audits, the use of trending factors, and an appropriate base
5 year determined by the office. The office may require independent
6 certification of data provided by a hospital to determine the hospital's
7 hospital specific limit.

8 (c) The office shall include a provision in each amendment to the
9 state plan regarding Medicaid disproportionate share payments that the
10 office submits to the federal Centers for Medicare and Medicaid
11 Services that, as provided in 42 CFR 447.297(d)(3), allows the state to
12 make additional disproportionate share expenditures after the end of
13 each federal fiscal year that relate back to a prior federal fiscal year.
14 However, the total disproportionate share payments to:

- 15 (1) each individual hospital; and
 - 16 (2) all qualifying hospitals in the aggregate;
- 17 may not exceed the limits provided by federal law and regulation.

18 (d) ~~The office shall, in each state fiscal year, provide sufficient~~
19 ~~funds for acute care hospitals licensed under IC 16-21 that qualify for~~
20 ~~disproportionate share payments under IC 12-15-16-1(a). Funds~~
21 ~~provided under this subsection:~~

- 22 (1) ~~do not include funds transferred by other governmental units~~
23 ~~to the Medicaid indigent care trust fund; and~~
- 24 (2) ~~must be in an amount equal to the amount that results from the~~
25 ~~following calculation:~~

26 ~~STEP ONE: Multiply twenty-six million dollars (\$26,000,000)~~
27 ~~by the federal medical assistance percentage.~~
28 ~~STEP TWO: Subtract the amount determined under STEP~~
29 ~~ONE from twenty-six million dollars (\$26,000,000).~~

30 **A hospital that receives a payment under clause (B) of STEP FIVE**
31 **of IC 12-15-15-1.5(c) is not eligible for a disproportionate share**
32 **payment under this section.**

33 SECTION 13. IC 12-15-19-6 IS AMENDED TO READ AS
34 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 6. (a) The office is not
35 required to make disproportionate share payments under this chapter
36 from the Medicaid indigent care trust fund established by
37 IC 12-15-20-1 until the fund has received sufficient deposits to permit
38 the office to make the state's share of the required disproportionate
39 share payments.

- 40 (b) If:
 - 41 (1) sufficient deposits have not been received; **or**
 - 42 (2) **the statewide Medicaid disproportionate share allocation**

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1 **is not sufficient to provide federal financial participation for**
 2 **the entirety of all eligible disproportionate share hospitals'**
 3 **specific limits;**
 4 the office ~~shall~~ **may** reduce disproportionate share payments **under**
 5 **IC 12-15-19-2.1** to all eligible institutions by ~~the same~~ a percentage as
 6 **long as, for each state fiscal year beginning after June 30, 2006, a**
 7 **hospital established under IC 16-22-8 receives at least sixty percent**
 8 **(60%) of the hospital's remaining hospital specific limit for each**
 9 **state fiscal year.** The percentage reduction shall be sufficient to ensure
 10 that payments do not exceed the **statewide Medicaid**
 11 **disproportionate share allocation or the** amounts that can be
 12 financed with the ~~state non-federal~~ share that is in the fund,
 13 **intergovernmental transfers, certifications of public expenditures,**
 14 **or other permissible sources of non-federal match.**

15 SECTION 14. IC 12-15-19-8 IS AMENDED TO READ AS
 16 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 8. (a) A provider that
 17 qualifies as a municipal disproportionate share provider under
 18 IC 12-15-16-1 shall receive a disproportionate share adjustment,
 19 subject to the provider's hospital specific limits described in subsection
 20 **(b) and the total amount available for municipal disproportionate**
 21 **share payments in subsection (d),** as follows:

22 (1) For each state fiscal year ending on or after June 30, 1998, an
 23 amount shall be distributed to each provider qualifying as a
 24 municipal disproportionate share provider under IC 12-15-16-1.
 25 The total amount distributed shall not exceed the sum of all
 26 hospital specific limits for all qualifying providers.

27 (2) For each municipal disproportionate share provider qualifying
 28 under IC 12-15-16-1 to receive disproportionate share payments,
 29 the amount in subdivision (1) shall be reduced by ~~the amount of~~
 30 disproportionate share payments received by the provider under
 31 ~~IC 12-15-16-6 or sections 1 or 2.1 of this chapter:~~ **all Medicaid**
 32 **payments, including Medicaid supplemental payments and**
 33 **other Medicaid disproportionate share payments received by**
 34 **the provider.** The office shall develop a disproportionate share
 35 provider payment methodology that ensures that each municipal
 36 disproportionate share provider receives disproportionate share
 37 payments that do not exceed the provider's hospital specific limit
 38 specified in subsection (b). The methodology developed by the
 39 office shall ensure that a municipal disproportionate share
 40 provider receives, to the extent possible, disproportionate share
 41 payments that, when combined with any other ~~disproportionate~~
 42 share **Medicaid supplemental** payments owed to the provider,

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1 ~~equals~~ **do not exceed** the provider's hospital specific limits.
 2 (b) Total disproportionate share payments to a provider under this
 3 chapter and IC 12-15-16 shall not exceed the hospital specific limit
 4 provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for
 5 state fiscal years ending on or before June 30, 1999, shall be
 6 determined by the office taking into account data provided by each
 7 hospital for the hospital's most recent fiscal year or, if a change in fiscal
 8 year causes the most recent fiscal period to be less than twelve (12)
 9 months, twelve (12) months of data compiled to the end of the
 10 provider's fiscal year that ends within the most recent state fiscal year,
 11 as certified to the office by an independent certified public accounting
 12 firm. The hospital specific limit for all state fiscal years ending on or
 13 after June 30, 2000, shall be determined by the office taking into
 14 account data provided by each hospital that is deemed reliable by the
 15 office based on a system of periodic audits, the use of trending factors,
 16 and an appropriate base year determined by the office. The office may
 17 require independent certification of data provided by a hospital to
 18 determine the hospital's hospital specific limit.

19 (c) For each of the state fiscal years:
 20 (1) beginning July 1, 1998, and ending June 30, 1999; and
 21 (2) beginning July 1, 1999, and ending June 30, 2000;
 22 the total municipal disproportionate share payments available under
 23 this section to qualifying municipal disproportionate share providers is
 24 twenty-two million dollars (\$22,000,000).

25 **(d) For each of the state fiscal years ending after June 30, 2006,**
 26 **the total municipal disproportionate share payments available**
 27 **under this section to qualifying municipal disproportionate share**
 28 **providers may not exceed thirty-five million dollars (\$35,000,000).**

29 SECTION 15. IC 12-15-19-10, AS AMENDED BY P.L.2-2005,
 30 SECTION 49, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 31 JULY 1, 2007]: Sec. 10. For state fiscal years beginning after June 30,
 32 2000, **and ending June 30, 2003**, the state shall pay providers as
 33 follows:

- 34 (1) The state shall make municipal disproportionate share
 35 provider payments to providers qualifying under IC 12-15-16-1(b)
 36 until the state exceeds the state disproportionate share allocation
 37 (as defined in 42 U.S.C. 1396r-4(f)(2)).
 38 (2) After the state makes all payments under subdivision (1), if
 39 the state fails to exceed the state disproportionate share allocation
 40 (as defined in 42 U.S.C. 1396r-4(f)(2)), the state shall make
 41 disproportionate share provider payments to providers qualifying
 42 under IC 12-15-16-1(a).

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1 (3) After the state makes all payments under subdivision (2), if
2 the state fails to exceed the state disproportionate share allocation
3 (as defined in 42 U.S.C. 1396r-4(f)(2)), or the state limit on
4 disproportionate share expenditures for institutions for mental
5 diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall make
6 community mental health center disproportionate share provider
7 payments to providers qualifying under IC 12-15-16-1(c).

8 SECTION 16. IC 12-15-20-2 IS AMENDED TO READ AS
9 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. The Medicaid
10 indigent care trust fund is established to pay the non-federal share of
11 the following:

12 (1) Enhanced disproportionate share payments to providers under
13 IC 12-15-19-1.

14 (2) Subject to subdivision (8), disproportionate share payments to
15 providers under IC 12-15-19-2.1.

16 (3) Medicaid payments for pregnant women described in
17 IC 12-15-2-13 and infants and children described in
18 IC 12-15-2-14.

19 (4) Municipal disproportionate share payments to providers under
20 IC 12-15-19-8.

21 (5) Payments to hospitals under IC 12-15-15-9.

22 (6) Payments to hospitals under IC 12-15-15-9.5.

23 (7) Payments, funding, and transfers as otherwise provided in
24 clauses (8)(D), ~~and~~ (8)(F), and **(8)(G)**.

25 (8) Of the intergovernmental transfers deposited into the
26 Medicaid indigent care trust fund, the following apply:

27 (A) The entirety of the intergovernmental transfers deposited
28 into the Medicaid indigent care trust fund for state fiscal years
29 ending on or before June 30, 2000, shall be used to fund the
30 state's share of the disproportionate share payments to
31 providers under IC 12-15-19-2.1.

32 (B) Of the intergovernmental transfers deposited into the
33 Medicaid indigent care trust fund for the state fiscal year
34 ending June 30, 2001, an amount equal to one hundred percent
35 (100%) of the total intergovernmental transfers deposited into
36 the Medicaid indigent care trust fund for the state fiscal year
37 beginning July 1, 1998, and ending June 30, 1999, shall be
38 used to fund the state's share of disproportionate share
39 payments to providers under IC 12-15-19-2.1. The remainder
40 of the intergovernmental transfers, if any, for the state fiscal
41 year shall be used to fund the state's share of additional
42 Medicaid payments to hospitals licensed under IC 16-21

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1 pursuant to a methodology adopted by the office.
 2 (C) Of the intergovernmental transfers deposited into the
 3 Medicaid indigent care trust fund, for state fiscal years
 4 beginning July 1, 2001, and July 1, 2002, an amount equal to:
 5 (i) one hundred percent (100%) of the total
 6 intergovernmental transfers deposited into the Medicaid
 7 indigent care trust fund for the state fiscal year beginning
 8 July 1, 1998; minus
 9 (ii) an amount equal to the amount deposited into the
 10 Medicaid indigent care trust fund under IC 12-15-15-9(d)
 11 **(before its repeal)** for the state fiscal years beginning July
 12 1, 2001, and July 1, 2002;
 13 shall be used to fund the state's share of disproportionate share
 14 payments to providers under IC 12-15-19-2.1. The remainder
 15 of the intergovernmental transfers, if any, must be used to fund
 16 the state's share of additional Medicaid payments to hospitals
 17 licensed under IC 16-21 pursuant to a methodology adopted by
 18 the office.
 19 (D) Of the intergovernmental transfers, which shall include
 20 amounts transferred under IC 12-16-7.5-4.5(b), STEP FOUR,
 21 deposited into the Medicaid indigent care trust fund for state
 22 fiscal years ending after June 30, 2003, **but before July 1,**
 23 **2005**, an amount equal to:
 24 (i) one hundred percent (100%) of the total
 25 intergovernmental transfers deposited into the Medicaid
 26 indigent care trust fund for the state fiscal year beginning
 27 July 1, 1998, and ending June 30, 1999; minus
 28 (ii) an amount equal to the amount deposited into the
 29 Medicaid indigent care trust fund under STEP FOUR of
 30 IC 12-16-7.5-4.5(b) for the state fiscal year ending after June
 31 30, 2003;
 32 shall be used to fund the non-federal share of disproportionate
 33 share payments to providers under IC 12-15-19-2.1. The
 34 remainder of the intergovernmental transfers, if any, for the
 35 state fiscal years shall be used to fund, in descending order of
 36 priority, the non-federal share of payments to hospitals under
 37 IC 12-15-15-9, the non-federal share of payments to hospitals
 38 under IC 12-15-15-9.5, the amount to be transferred under
 39 clause (F), and the non-federal share of payments under
 40 clauses (A) and (B) of STEP FIVE of IC 12-15-15-1.5(b).
 41 (E) The total amount of intergovernmental transfers used to
 42 fund the non-federal share of payments to hospitals under

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1 IC 12-15-15-9 and IC 12-15-15-9.5 shall not exceed the
2 amount calculated under STEP TWO of the following formula:
3 STEP ONE: Calculate the total amount of funds transferred to
4 the Medicaid indigent care trust fund under STEP FOUR of
5 IC 12-16-7.5-4.5(b).
6 STEP TWO: Multiply the state Medicaid medical assistance
7 percentage for the state fiscal year for which the payments
8 under IC 12-15-15-9 and IC 12-15-15-9.5 are to be made by
9 the amount calculated under STEP ONE.
10 (F) As provided in clause (D), for each fiscal year ending after
11 June 30, 2003, **but before July 1, 2005**, an amount equal to
12 the amount calculated under STEP THREE of the following
13 formula shall be transferred to the office:
14 STEP ONE: Calculate the product of thirty-five million dollars
15 (\$35,000,000) multiplied by the federal medical assistance
16 percentage for federal fiscal year 2003.
17 STEP TWO: Calculate the sum of the amounts, if any,
18 reasonably estimated by the office to be transferred or
19 otherwise made available to the office for the state fiscal year,
20 and the amounts, if any, actually transferred or otherwise made
21 available to the office for the state fiscal year, under
22 arrangements whereby the office and a hospital licensed under
23 IC 16-21-2 agree that an amount transferred or otherwise made
24 available to the office by the hospital or on behalf of the
25 hospital shall be included in the calculation under this STEP.
26 STEP THREE: Calculate the amount by which the product
27 calculated under STEP ONE exceeds the sum calculated under
28 STEP TWO.
29 **(G) For each fiscal year ending after June 30, 2005, the**
30 **total amount of intergovernmental transfers deposited into**
31 **the Medicaid indigent care trust fund shall be used as**
32 **follows:**
33 **(1) Thirty million dollars (\$30,000,000) shall be transferred to**
34 **the office for the Medicaid budget.**
35 **(2) An amount not to exceed eleven million six hundred fifty**
36 **thousand dollars (\$11,650,000) to fund the non-federal share**
37 **of payments to hospitals under IC 12-15-15-9 and**
38 **IC 12-15-15-9.5.**
39 **(3) An amount not to exceed eight million nine hundred**
40 **seventy-five thousand dollars (\$8,975,000) to fund the**
41 **non-federal share of payments to hospitals made under clause**
42 **(A) of STEP FIVE of IC 12-15-15-1.5(c).**

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1 **(4) To fund the non-federal share of payments to hospitals**
 2 **made under clause (B) of STEP FIVE of IC 12-15-15-1.5(c).**

3 **(5) To fund the non-federal share of payments to hospitals**
 4 **made under clause (C) of STEP FIVE of IC 12-15-15-1.5(c).**

5 **(6) To fund the non-federal share of disproportionate share**
 6 **payments to hospitals under IC 12-15-19-2.1.**

7 **(7) If additional funds are available after making payments**
 8 **under subdivisions (1) through (6), to fund other Medicaid**
 9 **supplemental payments for hospitals approved by the office**
 10 **and included in the state Medicaid plan.**

11 SECTION 17. IC 12-15-20.7-2 IS AMENDED TO READ AS
 12 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. **(a)** For each state
 13 fiscal year **ending before July 1, 2005**, subject to section 3 of this
 14 chapter, the office shall make the payments identified in this section in
 15 the following order:

16 (1) First, payments under IC 12-15-15-9 and IC 12-15-15-9.5.

17 (2) Second, payments under clauses (A) and (B) of STEP FIVE of
 18 IC 12-15-15-1.5(b).

19 (3) Third, Medicaid inpatient payments for safety-net hospitals
 20 and Medicaid outpatient payments for safety-net hospitals.

21 (4) Fourth, payments under IC 12-15-15-1.1 and 12-15-15-1.3.

22 (5) Fifth, payments under IC 12-15-19-8 for municipal
 23 disproportionate share hospitals.

24 (6) Sixth, payments under IC 12-15-19-2.1 for disproportionate
 25 share hospitals.

26 (7) Seventh, payments under clause (C) of STEP FIVE of
 27 IC 12-15-15-1.5(b).

28 **(b) For each state fiscal year ending after June 30, 2005, subject**
 29 **to section 3 of this chapter, the office shall make the payments**
 30 **identified in this section in the following order:**

31 (1) First, the payment under IC 12-15-20-2(8)(G).

32 (2) Second, payments under IC 12-15-15-1.1 and
 33 IC 12-15-15-1.3.

34 (3) Third, payments under IC 12-15-19-8.

35 (4) Fourth, payments under IC 12-15-15-9 and
 36 IC 12-15-15-9.5.

37 (5) Fifth, payments under clause (A) of STEP FIVE of
 38 IC 12-15-15-1.5(c).

39 (6) Sixth, payments under clause (B) of STEP FIVE of
 40 IC 12-15-15-1.5(c).

41 (7) Seventh, payments under clause (C) of STEP FIVE of
 42 IC 12-15-15-1.5(c).

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1 **(8) Eighth, payments under clause (D) of STEP FIVE of**
 2 **IC 12-15-15-1.5(c).**
 3 **(9) Ninth, payments under IC 12-15-19-2.1 for**
 4 **disproportionate share hospitals.**
 5 SECTION 18. IC 12-15-44 IS ADDED TO THE INDIANA CODE
 6 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
 7 JULY 1, 2007]:
 8 **Chapter 44. Healthier Indiana Insurance Program**
 9 **Sec. 1. As used in this chapter, "custodial parent" means the**
 10 **individual with whom a child resides and who is related to the child**
 11 **in one (1) of the following manners:**
 12 **(1) Legal or biological mother.**
 13 **(2) Legal or biological father.**
 14 **(3) A blood relative within the fifth degree of relation,**
 15 **including an individual who is related by half blood.**
 16 **(4) Stepfather, stepmother, stepbrother, or stepsister.**
 17 **(5) An individual who legally adopts a child or the child's**
 18 **parent, as well as relatives of the adoptive parents.**
 19 **(6) Legal spouses of an individual described in this subsection.**
 20 **Sec. 2. As used in this chapter, "preventative care services"**
 21 **means care that is provided to an individual for the purpose of**
 22 **preventing disease, diagnosing disease, or promoting good health.**
 23 **Sec. 3. As used in this chapter, "program" refers to the**
 24 **healthier Indiana insurance program established by IC 12-15-44-4.**
 25 **Sec. 4. (a) The healthier Indiana insurance program is**
 26 **established.**
 27 **(b) The office shall administer the program. The department of**
 28 **insurance and the office of the secretary shall provide oversight on**
 29 **the marketing practices of the program.**
 30 **(c) The following requirements apply to funds appropriated by**
 31 **the general assembly to the program:**
 32 **(1) At least ninety percent (90%) must be used to fund**
 33 **payment for health care services.**
 34 **(2) Not more than ten percent (10%) may be used to fund:**
 35 **(A) administrative costs; and**
 36 **(B) any profit derived from a contract entered into by a**
 37 **person to provide services for the program.**
 38 **(d) The program must include the following in a manner and to**
 39 **the extent determined by the office:**
 40 **(1) Mental health care services.**
 41 **(2) Inpatient hospital services.**
 42 **(3) Prescription drug coverage.**

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- 1 (4) Emergency room services.
- 2 (5) Physician office services.
- 3 (6) Diagnostic services.
- 4 (7) Outpatient services, including therapy services.
- 5 (8) Disease management.
- 6 (9) Home health services.
- 7 (10) Urgent care center services.

8 **Sec. 5. (a) An individual is eligible for the program if the**
 9 **individual meets the following requirements:**

- 10 (1) The individual is at least eighteen (18) years of age and less
- 11 than sixty-five (65) years of age.
- 12 (2) The individual is a United States citizen and has been a
- 13 resident of Indiana for at least twelve (12) months.
- 14 (3) The individual has an annual household income of:
- 15 (A) not more than two hundred percent (200%) of the
- 16 federal income poverty level if the individual is a custodial
- 17 parent; or
- 18 (B) at least one hundred percent (100%) and not more
- 19 than two hundred percent (200%) of the federal income
- 20 poverty level if the individual is not a custodial parent.
- 21 (4) The individual is not eligible for health insurance coverage
- 22 through the individual's employer.
- 23 (5) The individual has not had health insurance coverage for
- 24 at least six (6) months.
- 25 **(b) The following individuals are not eligible for this program:**
- 26 (1) An individual who participates in the federal Medicare
- 27 program (42 U.S.C. 1395 et seq.).
- 28 (2) A pregnant woman for purposes of pregnancy related
- 29 services.
- 30 (3) An individual who is eligible for the Medicaid program as
- 31 a disabled person.

32 **Sec. 6. (a) In order to participate in the program, an individual**
 33 **shall do the following:**

- 34 (1) Apply for the program on a form prescribed by the office.
- 35 The office may develop and allow a joint application for a
- 36 household.
- 37 (2) If the individual is approved by the office to participate in
- 38 the program, contribute to the individual's health care
- 39 account:
- 40 (A) at least one thousand one hundred dollars (\$1,100) per
- 41 year, but not more than five percent (5%) of the
- 42 individual's annual household income; or

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1 (B) one thousand one hundred dollars (\$1,100) per year
2 less the individual's contributions to the Medicaid program
3 under IC 12-15, the children's health insurance program
4 under IC 12-17.6, or the Medicare program (42 U.S.C.
5 1395 et seq.), as determined by the office.

6 (b) The state shall contribute the difference into the individual's
7 account if the individual's contribution of five percent (5%) of the
8 individual's annual income is less than the required one thousand
9 one hundred dollars (\$1,100).

10 (c) If the individual does not make the individual's contributions
11 to the program within thirty (30) days of the required payment, the
12 individual may be terminated from participating in the program.
13 The individual shall receive written notice before the individual is
14 terminated from the program.

15 (d) After termination from the program under subsection (c),
16 the individual may not reapply to participate in the program for
17 eighteen (18) months.

18 (e) An individual may be held responsible under the program
19 for receiving nonemergency services in an emergency room setting.
20 This may include requiring the individual to pay for services
21 received in the emergency room with money outside the
22 individual's health care account.

23 Sec. 7. (a) A participant must have a health care account in
24 which contributions are made by the participant, an employer, or
25 the office.

26 (b) The minimum amount in the account is the amount
27 contributed by the individual and the state as described in section
28 6 of this chapter.

29 (c) The account is to be used for paying the individual's
30 deductible for health care services in the program.

31 (d) The individual may contribute to the individual's health care
32 account through the following means:

33 (1) By the employer withholding or causing to be withheld
34 from the participating employee's wages or salary, after taxes
35 are taken out of the wages or salary, the participating
36 employee's required share described in this chapter and
37 distributed equally throughout the calendar year.

38 (2) By submitting the individual's required share to the office
39 to deposit into the individual's account in a manner
40 prescribed by the office.

41 (3) Any other means determined by the office.

42 Sec. 8. (a) The program must cover preventative care services,

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1 as determined by the office, for a participant of not more than five
2 hundred dollars (\$500) per year. This amount shall be paid by the
3 state at no cost to the participant.

4 (b) The office shall provide a participant with a list of health
5 care services that will qualify as preventative care services for the
6 age, gender, and preexisting conditions of the participant. The
7 office shall consult the federal Centers for Disease Control and
8 Prevention for a list of recommended preventative care services.

9 Sec. 9. (a) The office shall determine the health care services
10 covered under the program.

11 (b) The program is not an entitlement program, and the number
12 of individuals who may participate in the program is dependent
13 upon the funds appropriated for use for the plan.

14 Sec. 10. The program has the following per recipient coverage
15 limitations:

16 (1) An annual individual maximum coverage limitation of
17 three hundred thousand dollars (\$300,000).

18 (2) A lifetime individual maximum coverage of one million
19 dollars (\$1,000,000).

20 Sec. 11. (a) An individual who is approved to participate in the
21 program is eligible for a twelve (12) month period. Once the
22 individual has been approved for participation, the individual may
23 not be turned down for renewal into the program for the sole
24 reason that the program has reached the maximum number of
25 participants.

26 (b) If the individual chooses to renew participation in the
27 program, the individual shall complete a renewal application, any
28 necessary documentation, and submit the documentation and
29 application on a form prescribed by the office to the office in order
30 to continue participating in the program.

31 (c) If the individual chooses not to renew participation in the
32 program, the individual may not reapply to participate in the
33 program for at least eighteen (18) months.

34 Sec. 12. (a) An insurer or health maintenance organization that
35 has contracted with the office to provide health insurance for
36 individuals under this program:

37 (1) bears the risk of the health insurance program;

38 (2) is responsible for the claim processing under the program;

39 (3) shall reimburse providers at a reimbursement rate of:

40 (A) at least the federal Medicare reimbursement rate for
41 the service provided; or

42 (B) at a rate of one hundred thirty percent (130%) of the

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Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate; and (4) may not deny coverage to an eligible individual who has been approved by the office to participate in the program, except if the maximum coverage rates are met as described in section 10 of this chapter.

(b) An insurer or a health maintenance organization that has contracted with the office to provide health insurance under the program shall also offer to provide the same health insurance to the following:

- (1) An individual who has an annual household income that is:
 - (A) not more than two hundred percent (200%) of the federal income poverty level but the individual is not eligible for the program because of the individual's income or because a slot is not available for the individual; or
 - (B) more than two hundred percent (200%) of the federal income poverty level.
- (2) The employees of an employer if:
 - (A) the employees have an annual household income that is more than two hundred percent (200%) of the federal income poverty level; and
 - (B) the employer:
 - (i) has not offered employees health care insurance in the previous twelve (12) months; and
 - (ii) pays at least fifty percent (50%) of the premium for the employer's employees.

The state does not provide funding for coverage provided under this subsection.

Sec. 13. (a) A participant in the program has coverage for a period of twelve (12) months. If the participant would like to continue participating in the program, the participant must submit an application for renewal with the office as required in section 11 of this chapter.

(b) At the end an individual's twelve (12) month program period, and if the individual's health care account contains a balance of more than five hundred dollars (\$500), the individual may withdraw the money that exceeds five hundred dollars (\$500) from the account if the criteria specified in subsection (c) are met.

(c) The individual may only withdraw money from the individual's health care account if the following criteria are met:

- (1) The account has more than five hundred dollars (\$500) remaining.

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1 (2) The money being withdrawn is money that the individual,
2 not the state, contributed to the account and may not exceed
3 the total of the individual's contribution. The office shall
4 determine this amount by prorating the remaining amount
5 with the amount contributed by the individual.

6 (3) The individual has completed the individual's preventative
7 care services.

8 (4) Either:
9 (A) the individual is no longer eligible for the program
10 because the individual's annual household income exceeds
11 the amounts set forth in section 5(a)(3) of this chapter; or
12 (B) the money is used to pay for dental services or vision
13 services that are not covered under the program's plan.

14 (d) Money remaining in the account at the end of the
15 individual's twelve (12) month period that is not withdrawn as
16 allowed under subsection (c):

17 (1) remains in the account if the individual renews
18 participation in the program and the amount the individual
19 needs to contribute to the account in the following program
20 year is prorated based on the amount remaining in the
21 account; or

22 (2) is forfeited by the individual and reverts back to the state
23 if the individual:

24 (A) does not continue to participate in the program; or
25 (B) is terminated from the program under section 6 of this
26 chapter.

27 Sec. 14. (a) The healthier Indiana insurance fund is established
28 for the following purposes:

29 (1) Administering a program created by the general assembly
30 to provide health insurance for low income residents of the
31 state under this chapter.

32 (2) Providing copayments, preventative care services, and
33 premiums for individuals enrolled in the program.

34 (3) Funding tobacco use prevention and cessation programs
35 and programs designed to promote the general health and
36 well being of Indiana residents.

37 (4) Promoting research in the health and life sciences field,
38 including grants to universities for operating and capital
39 expenses.

40 The fund is apart from the state general fund.

41 (b) The fund shall be administered by the office of the secretary
42 of family and social services.

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1 (c) The expenses of administering the fund shall be paid from
2 money in the fund.

3 (d) The fund shall consist of the following:

4 (1) Cigarette tax revenues designated by the general assembly
5 to be part of the fund.

6 (2) Other funds designated by the general assembly to be part
7 of the fund.

8 (3) Federal funds available for the purposes of the fund.

9 (4) Gifts or donations to the fund.

10 (e) Money from each source going into the fund must be placed
11 into a separate account within the fund. Any unencumbered
12 balance in an account at the end of the state fiscal year that was
13 previously used for another program but diverted for use in this
14 program must be transferred back to the previous program.

15 (f) The treasurer of state shall invest the money in the fund not
16 currently needed to meet the obligations of the fund in the same
17 manner as other public money may be invested.

18 (g) Money must be appropriated before funds are available for
19 use.

20 (h) Money in the fund does not revert to the state general fund
21 at the end of any fiscal year.

22 Sec 15. (a) The office may not:

23 (1) enroll applicants;

24 (2) approve any contracts with vendors to provide services or
25 administer the program;

26 (3) incur costs other than those necessary to study and plan
27 for the implementation of the program; or

28 (4) create financial obligations for the state;

29 unless there is a specific appropriation from the general assembly
30 to implement the program.

31 (b) The office may not operate the program in a way that would
32 obligate the state to financial participation beyond the level of state
33 appropriations authorized for this purpose.

34 (c) The office shall:

35 (1) modify limitations on participation;

36 (2) modify services provided;

37 (3) establish or modify copayments; or

38 (4) otherwise limit program expansion;

39 in order to manage the program within the spending authorized by
40 the general assembly.

41 Sec. 16. The office may adopt rules under IC 4-22-2 necessary
42 to implement this chapter. The office may adopt emergency rules

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1 **under IC 4-22-2-37.1 to implement the program on an emergency**
2 **basis.**

3 SECTION 19. IC 12-16-7.5-4.5 IS AMENDED TO READ AS
4 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4.5. (a) Not later than
5 October 31 following the end of each state fiscal year, the division
6 shall:

7 (1) calculate for each county the total amount of payable claims
8 submitted to the division during the state fiscal year attributed to:

- 9 (A) patients who were residents of the county; and
- 10 (B) patients:
 - 11 (i) who were not residents of Indiana;
 - 12 (ii) whose state of residence could not be determined by the
 - 13 division; and
 - 14 (iii) who were residents of Indiana but whose county of
 - 15 residence in Indiana could not be determined by the
 - 16 division;

17 and whose medical condition that necessitated the care or
18 service occurred in the county;

19 (2) notify each county of the amount of payable claims attributed
20 to the county under the calculation made under subdivision (1);
21 and

22 (3) with respect to payable claims attributed to a county under
23 subdivision (1):

- 24 (A) calculate the total amount of payable claims submitted
25 during the state fiscal year for:
 - 26 (i) each hospital;
 - 27 (ii) each physician; and
 - 28 (iii) each transportation provider; and
- 29 (B) determine the amount of each payable claim for each
30 hospital, physician, and transportation provider listed in clause
31 (A).

32 (b) Before November 1 following the end of a state fiscal year, the
33 division shall allocate the funds transferred from a county's hospital
34 care for the indigent fund to the state hospital care for the indigent fund
35 under IC 12-16-14 during or for the state fiscal year as required under
36 the following STEPS:

37 STEP ONE: Determine the total amount of funds transferred from
38 a county's hospital care for the indigent fund by the county to the
39 state hospital care for the indigent fund under IC 12-16-14 during
40 or for the state fiscal year.

41 STEP TWO: Of the total amount of payable claims submitted to
42 the division during the state fiscal year attributed to the county

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1 under subsection (a), determine the amount of total hospital
2 payable claims, total physician payable claims, and total
3 transportation provider payable claims. Of the amounts
4 determined for physicians and transportation providers, calculate
5 the sum of those amounts as a percentage of an amount equal to
6 the sum of the total payable physician claims and total payable
7 transportation provider claims attributed to all the counties
8 submitted to the division during the state fiscal year.

9 STEP THREE: Multiply three million dollars (\$3,000,000) by the
10 percentage calculated under STEP TWO.

11 STEP FOUR: Transfer to the Medicaid indigent care trust fund
12 for purposes of IC 12-15-20-2(8)(D) or IC 12-15-20-2(8)(G) an
13 amount equal to the amount calculated under STEP ONE, minus
14 an amount equal to the amount calculated under STEP THREE.

15 STEP FIVE: The division shall retain an amount equal to the
16 amount remaining in the state hospital care for the indigent fund
17 after the transfer in STEP FOUR for purposes of making
18 payments under section 5 of this chapter.

19 (c) The costs of administering the hospital care for the indigent
20 program, including the processing of claims, shall be paid from the
21 funds transferred to the state hospital care for the indigent fund.

22 SECTION 20. IC 12-16-14-3, AS AMENDED BY P.L.246-2005,
23 SECTION 111, IS AMENDED TO READ AS FOLLOWS
24 [EFFECTIVE JULY 1, 2007]: Sec. 3. (a) For purposes of this section;
25 "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).

26 (b) (a) For taxes first due and payable in 2003, each county shall
27 impose a hospital care for the indigent property tax levy equal to the
28 product of:

- 29 (1) the county's hospital care for the indigent property tax levy for
30 taxes first due and payable in 2002; multiplied by
- 31 (2) the county's assessed value growth quotient determined under
32 IC 6-1.1-18.5-2 for taxes first due and payable in 2003.

33 (c) (b) For taxes first due and payable in 2004, 2005, 2006, 2007,
34 and 2008, and each year thereafter, each county shall impose a
35 hospital care for the indigent property tax levy equal to the product of:
36 hospital care for the indigent program property tax levy for taxes
37 first due and payable in the preceding calendar year multiplied by
38 the statewide average assessed value growth quotient, using all the
39 county assessed value growth quotients determined under
40 IC 6-1.1-18.5-2 for the year in which the tax levy under this
41 subsection will be first due and payable.

42 (1) the county's hospital care for the indigent property tax levy for

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1 taxes first due and payable in the preceding year; multiplied by
 2 (2) the assessed value growth quotient determined in the last
 3 STEP of the following STEPS:
 4 STEP ONE: Determine the three (3) calendar years that most
 5 immediately precede the ensuing calendar year and in which a
 6 statewide general reassessment of real property does not first
 7 become effective.
 8 STEP TWO: Compute separately, for each of the calendar years
 9 determined in STEP ONE; the quotient (rounded to the nearest
 10 ten-thousandth) of the county's total assessed value of all taxable
 11 property in the particular calendar year; divided by the county's
 12 total assessed value of all taxable property in the calendar year
 13 immediately preceding the particular calendar year.
 14 STEP THREE: Divide the sum of the three (3) quotients
 15 computed in STEP TWO by three (3):
 16 (d) Except as provided in subsection (e):
 17 (1) for taxes first due and payable in 2009; each county shall
 18 impose a hospital care for the indigent property tax levy equal to
 19 the average of the annual amount of payable claims attributed to
 20 the county under IC 12-16-7.5-4.5 during the state fiscal years
 21 beginning:
 22 (A) July 1, 2005;
 23 (B) July 1, 2006; and
 24 (C) July 1, 2007; and
 25 (2) for all subsequent annual levies under this section; the average
 26 annual amount of payable claims attributed to the county under
 27 IC 12-16-7.5-4.5 during the three (3) most recently completed
 28 state fiscal years.
 29 (e) A county may not impose an annual levy under subsection (d) in
 30 an amount greater than the product of:
 31 (1) The greater of:
 32 (A) the county's hospital care for the indigent property tax levy
 33 for taxes first due and payable in 2008; or
 34 (B) the amount of the county's maximum hospital care for the
 35 indigent property tax levy determined under this subsection for
 36 taxes first due and payable in the immediately preceding year;
 37 multiplied by
 38 (2) the assessed value growth quotient determined in the last
 39 STEP of the following STEPS:
 40 STEP ONE: Determine the three (3) calendar years that most
 41 immediately precede the ensuing calendar year and in which a
 42 statewide general reassessment of real property does not first

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1 become effective.

2 STEP TWO: Compute separately, for each of the calendar years

3 determined in STEP ONE, the quotient (rounded to the nearest

4 ten-thousandth) of the county's total assessed value of all taxable

5 property in the particular calendar year, divided by the county's

6 total assessed value of all taxable property in the calendar year

7 immediately preceding the particular calendar year.

8 STEP THREE: Divide the sum of the three (3) quotients

9 computed in STEP TWO by three (3).

10 SECTION 21. IC 27-8-5-16 IS AMENDED TO READ AS

11 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 16. Except as provided

12 in sections 17 and 24 of this chapter, no policy of group accident and

13 sickness insurance may be delivered or issued for delivery to a group

14 that has a legal situs in Indiana unless it conforms to one (1) of the

15 following descriptions:

16 (1) A policy issued to an employer or to the trustees of a fund

17 established by an employer (which employer or trustees must be

18 deemed the policyholder) to insure employees of the employer for

19 the benefit of persons other than the employer, subject to the

20 following requirements:

21 (A) The employees eligible for insurance under the policy

22 must be all of the employees of the employer, or all of any

23 class or classes of employees. The policy may provide that the

24 term "employees" includes the employees of one (1) or more

25 subsidiary corporations and the employees, individual

26 proprietors, members, and partners of one (1) or more

27 affiliated corporations, proprietorships, limited liability

28 companies, or partnerships if the business of the employer and

29 of the affiliated corporations, proprietorships, limited liability

30 companies, or partnerships is under common control. The

31 policy may provide that the term "employees" includes retired

32 employees, former employees, and directors of a corporate

33 employer. A policy issued to insure the employees of a public

34 body may provide that the term "employees" includes elected

35 or appointed officials.

36 (B) The premium for the policy must be paid either from the

37 employer's funds, from funds contributed by the insured

38 employees, or from both sources of funds. Except as provided

39 in clause (C), a policy on which no part of the premium is to

40 be derived from funds contributed by the insured employees

41 must insure all eligible employees, except those who reject the

42 coverage in writing.

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- 1 (C) An insurer may exclude or limit the coverage on any
 2 person as to whom evidence of individual insurability is not
 3 satisfactory to the insurer.
- 4 (2) A policy issued to a creditor or its parent holding company or
 5 to a trustee or trustees or agent designated by two (2) or more
 6 creditors (which creditor, holding company, affiliate, trustee,
 7 trustees, or agent must be deemed the policyholder) to insure
 8 debtors of the creditor, or creditors, subject to the following
 9 requirements:
- 10 (A) The debtors eligible for insurance under the policy must
 11 be all of the debtors of the creditor or creditors, or all of any
 12 class or classes of debtors. The policy may provide that the
 13 term "debtors" includes:
- 14 (i) borrowers of money or purchasers or lessees of goods,
 15 services, or property for which payment is arranged through
 16 a credit transaction;
- 17 (ii) the debtors of one (1) or more subsidiary corporations;
 18 and
- 19 (iii) the debtors of one (1) or more affiliated corporations,
 20 proprietorships, limited liability companies, or partnerships
 21 if the business of the policyholder and of the affiliated
 22 corporations, proprietorships, limited liability companies, or
 23 partnerships is under common control.
- 24 (B) The premium for the policy must be paid either from the
 25 creditor's funds, from charges collected from the insured
 26 debtors, or from both sources of funds. Except as provided in
 27 clause (C), a policy on which no part of the premium is to be
 28 derived from the funds contributed by insured debtors
 29 specifically for their insurance must insure all eligible debtors.
- 30 (C) An insurer may exclude any debtors as to whom evidence
 31 of individual insurability is not satisfactory to the insurer.
- 32 (D) The amount of the insurance payable with respect to any
 33 indebtedness may not exceed the greater of the scheduled or
 34 actual amount of unpaid indebtedness to the creditor. The
 35 insurer may exclude any payments that are delinquent on the
 36 date the debtor becomes disabled as defined in the policy.
- 37 (E) The insurance may be payable to the creditor or any
 38 successor to the right, title, and interest of the creditor. Each
 39 payment under this clause must reduce or extinguish the
 40 unpaid indebtedness of the debtor to the extent of the payment,
 41 and any excess of the insurance must be payable to the insured
 42 or the estate of the insured.

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1 (F) Notwithstanding clauses (A) through (E), insurance on
 2 agricultural credit transaction commitments may be written up
 3 to the amount of the loan commitment on a nondecreasing or
 4 level term plan, and insurance on educational credit
 5 transaction commitments may be written up to the amount of
 6 the loan commitment less the amount of any repayments made
 7 on the loan.

8 (3) A policy issued to a labor union or similar employee
 9 organization (which must be deemed to be the policyholder) to
 10 insure members of the union or organization for the benefit of
 11 persons other than the union or organization or any of its officials,
 12 representatives, or agents, subject to the following requirements:

13 (A) The members eligible for insurance under the policy must
 14 be all of the members of the union or organization, or all of
 15 any class or classes of members.

16 (B) The premium for the policy must be paid either from funds
 17 of the union or organization, from funds contributed by the
 18 insured members specifically for their insurance, or from both
 19 sources of funds. Except as provided in clause (C), a policy on
 20 which no part of the premium is to be derived from funds
 21 contributed by the insured members specifically for their
 22 insurance must insure all eligible members, except those who
 23 reject the coverage in writing.

24 (C) An insurer may exclude or limit the coverage on any
 25 person as to whom evidence of individual insurability is not
 26 satisfactory to the insurer.

27 (4) A policy issued to a trust or to one (1) or more trustees of a
 28 fund established or adopted by two (2) or more employers, or by
 29 one (1) or more labor unions or similar employee organizations,
 30 or by one (1) or more employers and one (1) or more labor unions
 31 or similar employee organizations (which trust or trustees must be
 32 deemed the policyholder) to insure employees of the employers
 33 or members of the unions or organizations for the benefit of
 34 persons other than the employers or the unions or organizations,
 35 subject to the following requirements:

36 (A) The persons eligible for insurance must be all of the
 37 employees of the employers or all of the members of the
 38 unions or organizations, or all of any class or classes of
 39 employees or members. The policy may provide that the term
 40 "employees" includes the employees of one (1) or more
 41 subsidiary corporations and the employees, individual
 42 proprietors, and partners of one (1) or more affiliated

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1 corporations, proprietorships, limited liability companies, or
 2 partnerships if the business of the employer and of the
 3 affiliated corporations, proprietorships, limited liability
 4 companies, or partnerships is under common control. The
 5 policy may provide that the term "employees" includes retired
 6 employees, former employees, and directors of a corporate
 7 employer. The policy may provide that the term "employees"
 8 includes the trustees or their employees, or both, if their duties
 9 are principally connected with the trusteeship.

10 (B) The premium for the policy must be paid from funds
 11 contributed by the employer or employers of the insured
 12 persons, by the union or unions or similar employee
 13 organizations, or by both, or from funds contributed by the
 14 insured persons or from both the insured persons and one (1)
 15 or more employers, unions, or similar employee organizations.
 16 Except as provided in clause (C), a policy on which no part of
 17 the premium is to be derived from funds contributed by the
 18 insured persons specifically for their insurance must insure all
 19 eligible persons, except those who reject the coverage in
 20 writing.

21 (C) An insurer may exclude or limit the coverage on any
 22 person as to whom evidence of individual insurability is not
 23 satisfactory to the insurer.

24 (5) A policy issued to an association or to a trust or to one (1) or
 25 more trustees of a fund established, created, or maintained for the
 26 benefit of members of one (1) or more associations. The
 27 association or associations must have at the outset a minimum of
 28 one hundred (100) persons, must have been organized and
 29 maintained in good faith for purposes other than that of obtaining
 30 insurance, must have been in active existence for at least one (1)
 31 year, and must have a constitution and bylaws that provide that
 32 the association or associations hold regular meetings not less than
 33 annually to further purposes of the members, that, except for
 34 credit unions, the association or associations collect dues or
 35 solicit contributions from members, and that the members have
 36 voting privileges and representation on the governing board and
 37 committees. The policy must be subject to the following
 38 requirements:

39 (A) The policy may insure members or employees of the
 40 association or associations, employees of members, one (1) or
 41 more of the preceding, or all of any class or classes of
 42 members, employees, or employees of members for the benefit

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of persons other than the employee's employer.

(B) The premium for the policy must be paid from funds contributed by the association or associations, by employer members, or by both, from funds contributed by the covered persons, or from both the covered persons and the association, associations, or employer members.

(C) Except as provided in clause (D), a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance must insure all eligible persons, except those who reject such coverage in writing.

(D) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(6) A policy issued to a credit union, or to one (1) or more trustees or an agent designated by two (2) or more credit unions (which credit union, trustee, trustees, or agent must be deemed the policyholder) to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee, trustees, or agent, or any of their officials, subject to the following requirements:

(A) The members eligible for insurance must be all of the members of the credit union or credit unions, or all of any class or classes of members.

(B) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in clause (C), must insure all eligible members.

(C) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

(7) A policy issued to cover persons in a group specifically described by another law of Indiana as a group that may be covered for group life insurance. The provisions of the group life insurance law relating to eligibility and evidence of insurability apply to a group health policy to which this subdivision applies.

(8) A policy issued to a trustee or agent designated by two (2) or more small employers (as defined in IC 27-8-15-14) as determined by the commissioner under rules adopted under IC 4-22-2.

SECTION 22. IC 27-8-5-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 17. (a) A group accident and sickness insurance policy shall not be delivered or issued

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1 for delivery in Indiana to a group that is not described in section
 2 16(1)(A), 16(2)(A), 16(3)(A), 16(4)(A), 16(5)(A), 16(6)(A), or 16(7),
 3 or 16(8) of this chapter unless the commissioner finds that:

- 4 (1) the issuance of the policy is not contrary to the best interest of
 5 the public;
 6 (2) the issuance of the policy would result in economies of
 7 acquisition or administration; and
 8 (3) the benefits of the policy are reasonable in relation to the
 9 premiums charged.

10 (b) Except as otherwise provided in this chapter, an insurer may
 11 exclude or limit the coverage under a policy described in subsection (a)
 12 on any person as to whom evidence of individual insurability is not
 13 satisfactory to the insurer.

14 SECTION 23. IC 27-8-10.1 IS ADDED TO THE INDIANA CODE
 15 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
 16 JULY 1, 2007]:

17 **Chapter 10.1. High Risk Hoosiers Under the Healthier Indiana**
 18 **Insurance Program**

19 **Sec. 1. As used in this chapter, "association" means the Indiana**
 20 **comprehensive health insurance association established by**
 21 **IC 27-8-10-2.1.**

22 **Sec. 2. As used in this chapter, "covered individual" means an**
 23 **individual entitled to coverage under the program.**

24 **Sec. 3. As used in this chapter, "program" refers to the**
 25 **healthier Indiana insurance program established by IC 12-15-44-4.**

26 **Sec. 4. (a) The association shall administer the program for**
 27 **individuals who are referred to the association by the office of the**
 28 **secretary of family and social services.**

29 **(b) Coverage under the program is separate from the coverage**
 30 **provided under IC 27-8-10.**

31 **(c) The following apply to the administration of the program**
 32 **under this chapter:**

33 **(1) Only individuals referred by the office of the secretary of**
 34 **family and social services are eligible for program coverage**
 35 **administered under this chapter.**

36 **(2) Program coverage administered under this chapter must**
 37 **provide medical management services.**

38 **(d) A covered individual shall participate in medical**
 39 **management services provided under this chapter.**

40 SECTION 24. [EFFECTIVE UPON PASSAGE] **(a) As used in this**
 41 **SECTION, "office" refers to the office of Medicaid policy and**
 42 **planning established by IC 12-8-6-1.**

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1 **(b) The office shall apply to the United States Department of**
 2 **Health and Human Services for approval of a Section 1115**
 3 **demonstration waiver to develop and implement a health insurance**
 4 **program to cover individuals who meet the following**
 5 **requirements:**

6 **(1) The individual is at least eighteen (18) years of age and less**
 7 **than sixty-five (65) years of age.**

8 **(2) The individual is a United States citizen and has been a**
 9 **resident of Indiana for at least twelve (12) months.**

10 **(3) The individual has an annual household income of:**

11 **(A) not more than two hundred percent (200%) of the**
 12 **federal income poverty level if the individual is a custodial**
 13 **parent; or**

14 **(B) at least one hundred percent (100%) and not more**
 15 **than two hundred percent (200%) of the federal income**
 16 **poverty level if the individual is not a custodial parent.**

17 **(4) The individual is not eligible for health insurance coverage**
 18 **through the individual's employer.**

19 **(5) The individual has been without health insurance coverage**
 20 **for at least six (6) months or is without health insurance**
 21 **coverage because of a change in employment.**

22 **(c) The office shall include in the waiver application a request**
 23 **to fund the program in part by using:**

24 **(1) costs not otherwise matchable dollars; and**

25 **(2) hospital care for the indigent dollars, upper payment limit**
 26 **dollars, or disproportionate share hospital dollars.**

27 **(d) The office may not implement the waiver until the office:**

28 **(1) files an affidavit with the governor attesting that the**
 29 **federal waiver applied for under this SECTION is in effect;**
 30 **and**

31 **(2) has sufficient funding for the program.**

32 **The office shall file the affidavit under this subsection not later**
 33 **than five (5) days after the office is notified that the waiver is**
 34 **approved.**

35 **(e) The office may adopt rules under IC 4-22-2 necessary to**
 36 **implement this SECTION.**

37 **(f) This SECTION expires December 31, 2013.**

38 **SECTION 25. [EFFECTIVE UPON PASSAGE] (a) As used in this**
 39 **SECTION, "office" refers to the office of Medicaid policy and**
 40 **planning established by IC 12-8-6-1.**

41 **(b) The office shall apply to the United States Department of**
 42 **Health and Human Services for approval of an amendment to the**

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1 state's Medicaid plan that is necessary to do the following:

2 (1) Include coverage under the state's Medicaid program for
3 pregnancy related services for a pregnant woman whose
4 annual household income does not exceed two hundred
5 percent (200%) of the federal income poverty level.

6 (2) Amend the state's upper payment limit program.

7 (3) Make changes to the state's disproportionate share
8 hospital program.

9 (c) The office may not implement an approved amendment to
10 the state plan until the office files an affidavit with the governor
11 attesting that the state plan amendment applied for under
12 subsection (b)(1), (b)(2), or (b)(3) of this SECTION is in effect. The
13 office shall file the affidavit under this subsection not later than
14 five (5) days after the office is notified that the state plan
15 amendment is approved.

16 (d) The office may adopt rules under IC 4-22-2 necessary to
17 implement this SECTION.

18 (e) This SECTION expires December 31, 2013.

19 SECTION 26. [EFFECTIVE UPON PASSAGE] (a) As used in this
20 SECTION, "commission" refers to the health finance commission
21 established by IC 2-5-23-3.

22 (b) As used in this SECTION, "office" refers to the office of
23 Medicaid policy and planning established by IC 12-8-6-1.

24 (c) The office shall report to the commission during the 2007
25 interim, updating the commission on the status of the development
26 and implementation of the healthier Indiana insurance program
27 established by IC 12-15-44-4, as added by this act.

28 (d) This SECTION expires December 31, 2008.

29 SECTION 27. [EFFECTIVE UPON PASSAGE] (a) As used in this
30 SECTION, "small employer" means any person, firm, corporation,
31 limited liability company, partnership, or association actively
32 engaged in business who, on at least fifty percent (50%) of the
33 working days of the employer during the preceding calendar year,
34 employed at least two (2) but not more than fifty (50) eligible
35 employees, the majority of whom work in Indiana. In determining
36 the number of eligible employees, companies that are affiliated
37 companies or that are eligible to file a combined tax return for
38 purposes of state taxation are considered one (1) employer.

39 (b) The commissioner of the department of insurance and the
40 office of the secretary of family and social services shall, not later
41 than January 1, 2008, implement a program to allow two (2) or
42 more small employers to join together to purchase health

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1 **insurance, as described in IC 27-8-5-16(8), as amended by this act.**
2 **(c) The commissioner shall adopt rules under IC 4-22-2**
3 **necessary to implement this SECTION.**
4 **SECTION 28. An emergency is declared for this act.**

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SENATE MOTION

Madam President: I move that Senator Simpson be added as second author of Senate Bill 503.

MILLER

SENATE MOTION

Madam President: I move that Senator Errington be added as coauthor of Senate Bill 503.

MILLER

SENATE MOTION

Madam President: I move that Senator Sipes be added as coauthor of Senate Bill 503.

MILLER

SENATE MOTION

Madam President: I move that Senator Becker be added as third author and Senator Rogers be added as coauthor of Senate Bill 503.

MILLER

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 503, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 6, line 36, strike "shortfall" and insert "**supplemental payment**".

Page 6, line 40, strike "Payment for a state fiscal year ending after



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June 30,".

Page 6, strike line 41.

Page 6, line 42, strike "year's end.".

Page 7, line 9, strike "STEP SEVEN of".

Page 7, strike lines 10 through 12.

Page 7, line 13, strike "(b)." and insert "**this section.**".

Page 7, line 14, after "section" insert ".".

Page 7, line 14, strike "and as otherwise provided under".

Page 7, line 15, delete "IC 12-15-20-2(6)".

Page 7, line 17, strike "subsection (d)" and insert "**this section**".

Page 7, line 18, strike "STEP SEVEN of".

Page 7, line 22, strike "STEP".

Page 7, line 23, strike "SEVEN of".

Page 7, line 26, strike "STEP SEVEN of".

Page 7, line 32, strike "shortfall" and insert "**supplemental payment**".

Page 8, line 5, strike "shortfall" and insert "**supplemental payment**".

Page 9, line 16, strike "shortfall" and insert "**supplemental payment**".

Page 9, line 18, strike "Subject to subsection (e), the reimbursement for a state fiscal".

Page 9, strike line 19.

Page 9, line 20, strike "following the end of the state fiscal year.".

Page 9, line 22, strike "under subsection (d)." and insert "**by the hospital or on behalf of the hospital.**".

Page 9, line 29, strike "STEP SEVEN of".

Page 9, line 30, strike "In determining the percentage, the office shall apply the".

Page 9, strike lines 31 through 32.

Page 9, line 33, strike "(b)".

Page 9, line 34, after "section" insert ".".

Page 9, line 34, strike "and as otherwise provided under".

Page 9, line 35, delete "IC 12-15-20-2(6)".

Page 9, line 37, strike "subsection (d)" and insert "**this section**".

Page 9, line 38, strike "STEP SEVEN of".

Page 9, line 42, strike "STEP".

Page 10, line 1, strike "SEVEN of".

Page 10, line 4, strike "STEP SEVEN of".

Page 10, line 10, strike "shortfall" and insert "**supplemental payment**".

Page 10, line 25, strike "shortfall" and insert "**supplemental**".

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payment".

Page 11, line 1, after "2003," insert "**and before July 1, 2005,**".

Page 11, line 27, reset in roman "IC 12-15-20-2(8)(D)".

Page 11, line 27, delete "**IC 12-15-20-2(6)(D)**".

Page 12, strike lines 18 through 21.

Page 12, between lines 21 and 22, begin a new paragraph and insert:

"(c) For state fiscal years ending after July 1, 2005, in addition to reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by a hospital described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified under STEP ONE, the office shall calculate the total payments made under this article and under the state Medicaid plan to a hospital described in subsection (a), excluding payments made under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the total amount that would have been paid by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) Subject to the availability of funds under IC 12-15-20-2(7) to serve as the non-federal share of the payments, the amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis based on the hospitals' Medicaid inpatient days or, if the federal Centers for Medicare and Medicaid Services do not approve that methodology, another payment methodology approved by the federal Centers for Medicare and Medicaid Services. For purposes of this clause, a hospital's Medicaid inpatient days are the

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hospital's in-state Medicaid paid claims and Medicaid managed care days for the state fiscal year referenced in STEP ONE, as determined by the office.

(B) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clause (A), the remaining amount shall be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause only if the hospital:

- (i) has less than seventy thousand (70,000) Medicaid inpatient days annually;
- (ii) was eligible for disproportionate share hospital payments under IC 12-15-19-2.1 for the state fiscal year ending June 30, 1998, or the hospital met the office's Medicaid disproportionate share payment criteria for payment under IC 12-15-19-2.1 based upon state fiscal year 1998 data and received a Medicaid disproportionate share payment for the state fiscal year ending June 30, 2001; and
- (iii) received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004.

The amount of a hospital's payment under this clause is subject to the extent that Medicaid indigent care trust funds are available or, if none are available, the non-federal share of the hospital's payment is provided by or on behalf of the hospital. The payment to each hospital shall equal the hospital's hospital specific limit provided under 42 U.S.C. 1396r-4 when the payments are combined with any other Medicaid payments made to the hospital. For state fiscal years ending before July 1, 2008, the total payments made under this clause may not exceed a total amount of sixty-eight million dollars (\$68,000,000). For a state fiscal year ending after June 30, 2008, the total payments made under this clause may not exceed a total amount of sixty-eight million dollars (\$68,000,000) plus the annual percentage growth in the state's aggregate Medicaid upper payment limit, as calculated by the office.

(C) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) and (B), the remaining amount may be paid to hospitals described in

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subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause if the hospital:

- (i) has less than seventy thousand (70,000) Medicaid inpatient days annually;
- (ii) has received or is eligible to receive Medicaid disproportionate share payments under IC 12-15-19-2.1 for state fiscal years 2002, 2003, 2004, and for each state fiscal year after 2004; and
- (iii) provides, or has provided on the hospital's behalf, the non-federal share of the hospital's payment.

A payment to a hospital under this clause is subject to the availability of non-federal dollars. The payment to each hospital shall not exceed ninety percent (90%) of the hospital's Medicaid shortfall. As used in this clause, Medicaid shortfall is the amount of the hospital's Medicaid costs less the hospital's Medicaid reimbursement and any payments received by the hospital under IC 12-15-15-9 and IC 12-15-15-9.5. For state fiscal years ending before July 1, 2008, the total payments made under this clause may not exceed a total amount of twenty-three million five hundred thousand dollars (\$23,500,000). For a state fiscal year ending after June 30, 2008, the total payments made under this clause may not exceed a total amount of twenty-three million five hundred thousand dollars (\$23,500,000) plus the annual percentage growth in the state's aggregate Medicaid upper payment limit, as determined by the office. (D) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) through (C), the remaining amount shall be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for payment under this clause if the hospital provides, or has provided on the hospital's behalf, the non-federal share of the hospital's payment.

(E) As used in clauses (A) through (D), a hospital's Medicaid inpatient days are based on the hospital's Medicaid paid claims and Medicaid managed care days for the current state fiscal year, as determined by the office."

Page 12, line 24, delete "." and insert "**or subsection (c).**".

Page 12, line 25, after "(b)" insert "**or subsection (c)**".

Page 12, line 28, after "(b)" insert "**or subsection (c)**".

Page 12, between lines 32 and 33, begin a new paragraph and insert:

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"SECTION 8. IC 12-15-15-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

- (1) who is a resident of the county;
- (2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or
- (3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, **and before July 1, 2006**, a hospital licensed under IC 16-21-2 that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5 is entitled to a payment under ~~this section~~: **subsection (c)**.

(c) Except as provided in section 9.8 of this chapter and subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP SIX of the following STEPS:

STEP ONE: Identify:

- (A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 during the state fiscal year; and
- (B) the county to which each payable claim is attributed.

STEP TWO: For each county identified in STEP ONE, identify:

- (A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 attributed to the county during the state fiscal year; and
- (B) the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP THREE: For each county identified in STEP ONE, identify the amount of county funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP FOUR: For each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, calculate the

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hospital's percentage share of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b). Each hospital's percentage share is based on the total amount of the hospital's payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year, calculated as a percentage of the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year. STEP FIVE: Subject to subsection (j), for each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, multiply the hospital's percentage share calculated under STEP FOUR by the amount of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP SIX: Determine the sum of all amounts calculated under STEP FIVE for each hospital identified in STEP ONE with respect to each county identified in STEP ONE.

(d) For state fiscal years beginning after June 30, 2006, a hospital that received a payment determined under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2006, shall be paid in an amount equal to the amount determined for the hospital under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2006.

~~(d)~~ (e) A hospital's payment under subsection (c) **or (d)** is in the form of a Medicaid ~~add-on~~ **supplemental** payment. The amount of a hospital's ~~add-on~~ **Medicaid supplemental** payment is subject to the availability of funding for the non-federal share of the payment under subsection ~~(e)~~. **(f)**. The office shall make the payments under ~~subsection~~ **subsections (c) and (d)** before December 15 that next succeeds the end of the state fiscal year.

~~(e)~~ **(f)** The non-federal share of a payment to a hospital under subsection (c) **or (d)** is funded from the funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) of each county to which a payable claim under IC 12-16-7.5 submitted to the division during the state fiscal year by the hospital is attributed.

~~(f)~~ **(g)** The amount of a county's transferred funds available to be used to fund the non-federal share of a payment to a hospital under subsection (c) **or (d)** is an amount that bears the same proportion to the total amount of funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) that the total amount of the hospital's payable claims under IC 12-16-7.5 attributed

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to the county submitted to the division during the state fiscal year bears to the total amount of all hospital payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year.

~~(g)~~ **(h)** Any county's funds identified in subsection ~~(f)~~ **(g)** that remain after the non-federal share of a hospital's payment has been funded are available to serve as the non-federal share of a payment to a hospital under section 9.5 of this chapter.

~~(h)~~ **(i)** For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).

~~(i)~~ **(j)** For purposes of this section:

(1) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(2) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

~~(j)~~ **(k)** The amount calculated under STEP FIVE of subsection (c) for a hospital with respect to a county may not exceed the total amount of the hospital's payable claims attributed to the county during the state fiscal year."

Page 13, line 6, after "2003," insert "**but before July 1, 2006,**".

Page 13, line 14, strike "this section." and insert "**subsection (c).**".

Page 14, between lines 15 and 16, begin a new paragraph and insert:

"(d) For state fiscal years beginning after June 30, 2006, a hospital that received a payment determined under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2006, will be paid an amount equal to the amount determined for the hospital under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2006."

Page 14, line 16, strike "(d)" and insert "**(e)**".

Page 14, line 16, after "(c)" insert "**or (d)**".

Page 14, line 17, strike "add-on" and insert "**supplemental**".

Page 14, line 19, strike "(e)." and insert "**(f)**".

Page 14, line 20, after "(c)" insert "**or (d)**".

Page 14, line 22, strike "(e)" and insert "**(f)**".

Page 14, line 23, after "(c)" insert "**or (d)**".

Page 14, line 25, strike "To the extent possible,".

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Page 14, strike lines 26 through 41.

Page 14, line 42, strike "(f)" and insert "(g)".

Page 14, line 42, strike "(g)," and insert "(h)",

Page 15, line 3, strike "(g)" and insert "(h)".

Page 15, line 12, strike "(h)" and insert "(i)".

Page 15, line 15, delete "IC 12-15-20-2(6)(D)." and insert "**IC 12-15-20-2(8).**".

Page 15, line 16, strike "(i)" and insert "(j)".

Page 16, line 21, after "under" insert "**IC 12-15-16, IC 12-15-17, or IC 12-15-19 of**".

Page 16, line 31, strike "or".

Page 16, line 33, delete "." and insert "; **or**

(3) other permissible sources of non-federal share dollars.".

Page 16, between lines 40 and 41, begin a new paragraph and insert:

"SECTION 12. IC 12-15-19-2.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2.1. (a) For each state fiscal year ending on or after June 30, 2000, the office shall develop a disproportionate share payment methodology that ensures that each hospital qualifying for disproportionate share payments under IC 12-15-16-1(a) timely receives total disproportionate share payments that do not exceed the hospital's hospital specific limit provided under 42 U.S.C. 1396r-4(g). The payment methodology as developed by the office must:

- (1) maximize disproportionate share hospital payments to qualifying hospitals to the extent practicable;
- (2) take into account the situation of those qualifying hospitals that have historically qualified for Medicaid disproportionate share payments; and
- (3) ensure that payments net of intergovernmental transfers made by or on behalf of qualifying hospitals are equitable.

(b) Total disproportionate share payments to a hospital under this chapter shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, the use of trending factors, and an appropriate base year determined by the office. The office may require independent certification of data provided by a hospital to determine the hospital's hospital specific limit.

(c) The office shall include a provision in each amendment to the state plan regarding Medicaid disproportionate share payments that the office submits to the federal Centers for Medicare and Medicaid

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Services that, as provided in 42 CFR 447.297(d)(3), allows the state to make additional disproportionate share expenditures after the end of each federal fiscal year that relate back to a prior federal fiscal year. However, the total disproportionate share payments to:

- (1) each individual hospital; and
- (2) all qualifying hospitals in the aggregate;

may not exceed the limits provided by federal law and regulation.

(d) ~~The office shall, in each state fiscal year, provide sufficient funds for acute care hospitals licensed under IC 16-21 that qualify for disproportionate share payments under IC 12-15-16-1(a). Funds provided under this subsection:~~

- ~~(1) do not include funds transferred by other governmental units to the Medicaid indigent care trust fund; and~~
- ~~(2) must be in an amount equal to the amount that results from the following calculation:~~

~~STEP ONE: Multiply twenty-six million dollars (\$26,000,000) by the federal medical assistance percentage.~~

~~STEP TWO: Subtract the amount determined under STEP ONE from twenty-six million dollars (\$26,000,000).~~

A hospital that receives a payment under clause (B) of STEP FIVE of IC 12-15-15-1.5(c) is not eligible for a disproportionate share payment under this section.

SECTION 13. IC 12-15-19-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 6. (a) The office is not required to make disproportionate share payments under this chapter from the Medicaid indigent care trust fund established by IC 12-15-20-1 until the fund has received sufficient deposits to permit the office to make the state's share of the required disproportionate share payments.

(b) If:

- (1) sufficient deposits have not been received; **or**
- (2) the statewide Medicaid disproportionate share allocation is not sufficient to provide federal financial participation for the entirety of all eligible disproportionate share hospitals' specific limits;**

the office ~~shall~~ **may** reduce disproportionate share payments **under IC 12-15-19-2.1** to all eligible institutions by ~~the same~~ **a percentage as long as, for each state fiscal year beginning after June 30, 2006, a hospital established under IC 16-22-8 receives at least sixty percent (60%) of the hospital's remaining hospital specific limit for each state fiscal year.** The percentage reduction shall be sufficient to ensure that payments do not exceed the **statewide Medicaid**

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disproportionate share allocation or the amounts that can be financed with the state non-federal share that is in the fund, intergovernmental transfers, certifications of public expenditures, or other permissible sources of non-federal match."

Page 17, line 4, delete "," and insert **"and the total amount available for municipal disproportionate share payments in subsection (d),"**

Page 17, line 12, strike "the amount of".

Page 17, strike line 13.

Page 17, line 14, strike "IC 12-15-16-6 or sections 1 or 2.1 of this chapter." and insert **"all Medicaid payments, including Medicaid supplemental payments and other Medicaid disproportionate share payments received by the provider."**

Page 17, line 22, strike "disproportionate share" and insert **"Medicaid supplemental"**.

Page 17, line 23, strike "equals" and insert **"do not exceed"**.

Page 18, line 8, delete "is forty million dollars (\$40,000,000)." and insert **"may not exceed thirty-five million dollars (\$35,000,000)."**

Page 18, between lines 8 and 9, begin a new paragraph and insert:
"SECTION 14. IC 12-15-19-10, AS AMENDED BY P.L.2-2005, SECTION 49, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 10. For state fiscal years beginning after June 30, 2000, **and ending June 30, 2003**, the state shall pay providers as follows:

- (1) The state shall make municipal disproportionate share provider payments to providers qualifying under IC 12-15-16-1(b) until the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)).
- (2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)), the state shall make disproportionate share provider payments to providers qualifying under IC 12-15-16-1(a).
- (3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)), or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall make community mental health center disproportionate share provider payments to providers qualifying under IC 12-15-16-1(c)."

Page 18, reset in roman lines 22 and 23.

Page 18, line 24, reset in roman "(7)".

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- Page 18, line 24, delete "(5)".
- Page 18, line 25, after "(D)" insert ",".
- Page 18, line 25, strike "and".
- Page 18, line 25, delete "." and insert ", and (8)(G)".
- Page 18, line 26, reset in roman "(8)".
- Page 18, line 26, delete "(6)".
- Page 19, line 23, after "2003," insert "**but before July 1, 2005,**".
- Page 19, line 36, reset in roman "the non-federal share of payments to hospitals under".
- Page 19, reset in roman line 37.
- Page 19, line 38, reset in roman "under IC 12-15-15-9.5".
- Page 19, reset in roman lines 41 through 42.
- Page 20, reset in roman lines 1 through 9.
- Page 20, line 10, reset in roman "(F)".
- Page 20, line 10, delete "(E)".
- Page 20, line 11, delete "2006," and insert "**2005,**".
- Page 20, line 29, delete "(F)" and insert "**(G)**".
- Page 20, line 29, delete "2006," and insert "**2005,**".
- Page 20, line 30, delete "entirety of the" and insert "**total amount of**".
- Page 20, line 31, delete "for" and insert "**as follows:**"
 - (1) Thirty million dollars (\$30,000,000) shall be transferred to the office for the Medicaid budget.**
 - (2) An amount not to exceed eleven million six hundred fifty thousand dollars (\$11,650,000) to fund the non-federal share of payments to hospitals under IC 12-15-15-9 and IC 12-15-15-9.5.**
 - (3) An amount not to exceed eight million nine hundred seventy-five thousand dollars (\$8,975,000) to fund the non-federal share of payments to hospitals made under clause (A) of STEP FIVE of IC 12-15-15-1.5(c).**
 - (4) To fund the non-federal share of payments to hospitals made under clause (B) of STEP FIVE of IC 12-15-15-1.5(c).**
 - (5) To fund the non-federal share of payments to hospitals made under clause (C) of STEP FIVE of IC 12-15-15-1.5(c).**
 - (6) To fund the non-federal share of disproportionate share payments to hospitals under IC 12-15-19-2.1.**
 - (7) If additional funds are available after making payments under subdivisions (1) through (6), to fund other Medicaid supplemental payments for hospitals approved by the office and included in the state Medicaid plan."**
- Page 20, delete lines 32 through 34.

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Page 20, line 36, after "Sec. 2." insert "(a)".

Page 20, line 37, delete "year," and insert "year **ending before July 1, 2005,**".

Page 20, reset in roman line 39.

Page 20, line 40, reset in roman "(2) Second,".

Page 20, line 40, delete "(1) First,".

Page 20, line 42, reset in roman "(3) Third,".

Page 20, line 42, delete "(2) Second,".

Page 21, reset in roman line 3.

Page 21, line 4, reset in roman "(5) Fifth,".

Page 21, line 4, delete "(3) Third,".

Page 21, line 6, reset in roman "(6) Sixth,".

Page 21, line 6, delete "(4) Fourth,".

Page 21, reset in roman lines 8 and 9.

Page 21, between lines 9 and 10, begin a new paragraph and insert:
"(b) For each state fiscal year ending after June 30, 2005, subject to section 3 of this chapter, the office shall make the payments identified in this section in the following order:

(1) First, the payment under IC 12-15-20-2(8)(G).

(2) Second, payments under IC 12-15-15-1.1 and IC 12-15-15-1.3.

(3) Third, payments under IC 12-15-19-8.

(4) Fourth, payments under IC 12-15-15-9 and IC 12-15-15-9.5.

(5) Fifth, payments under clause (A) of STEP FIVE of IC 12-15-15-1.5(c).

(6) Sixth, payments under clause (B) of STEP FIVE of IC 12-15-15-1.5(c).

(7) Seventh, payments under clause (C) of STEP FIVE of IC 12-15-15-1.5(c).

(8) Eighth, payments under clause (D) of STEP FIVE of IC 12-15-15-1.5(c).

(9) Ninth, payments under IC 12-15-19-2.1 for disproportionate share hospitals."

Page 21, line 32, after "program." insert "**The department of insurance and the office of the secretary shall provide oversight on the marketing practices of the program.**".

Page 21, between lines 40 and 41, begin a new paragraph and insert:

"(d) The program must include the following in a manner and to the extent determined by the office:

(1) Mental health care services.

(2) Inpatient hospital services.

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- (3) Prescription drug coverage.**
- (4) Emergency room services.**
- (5) Physician office services.**
- (6) Diagnostic services.**
- (7) Outpatient services, including therapy services.**
- (8) Disease management.**
- (9) Home health services.**
- (10) Urgent care center services."**

Page 24, line 25, after "Sec. 12." insert "(a)".

Page 24, between lines 39 and 40, begin a new paragraph and insert:

"(b) An insurer or a health maintenance organization that has contracted with the office to provide health insurance under the program shall also offer to provide the same health insurance to the following:

- (1) An individual who has an annual household income that is:**
 - (A) not more than two hundred percent (200%) of the federal income poverty level but the individual is not eligible for the program because of the individual's income or because a slot is not available for the individual; or**
 - (B) more than two hundred percent (200%) of the federal income poverty level.**
- (2) The employees of an employer if:**
 - (A) the employees have an annual household income that is more than two hundred percent (200%) of the federal income poverty level; and**
 - (B) the employer:**
 - (i) has not offered employees health care insurance in the previous twelve (12) months; and**
 - (ii) pays at least fifty percent (50%) of the premium for the employer's employees.**

The state does not provide funding for coverage provided under this subsection."

Page 25, line 19, delete "The" and insert "**Either:**

- (A) the individual is no longer eligible for the program because the individual's annual household income exceeds the amounts set forth in section 5(a)(3) of this chapter; or**
- (B) the"**

Page 27, delete lines 10 through 42.

Delete page 28.

Page 29, delete lines 1 through 33.

Page 30, line 21, delete "Except as provided in subsection (c), before" and insert "Before".

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Page 31, line 1, reset in roman "IC 12-15-20-2(8)(D)".

Page 31, line 1, delete "IC 12-15-20-2(6)(D)" and insert "**or IC 12-15-20-2(8)(G)**".

Page 31, delete lines 8 through 24.

Page 31, line 25, reset in roman "(c)".

Page 31, line 25, delete "(d)".

Page 31, line 30, strike "(a) For purposes of this section,".

Page 31, strike line 31.

Page 31, line 32, strike "(b)" and insert "**(a)**".

Page 31, line 39, strike "(c)" and insert "**(b)**".

Page 31, line 39, reset in roman "first".

Page 31, line 39, after "payable" delete ",".

Page 31, line 39, reset in roman "in 2004,".

Page 31, line 40, after "2008," insert "**and each year thereafter,**".

Page 31, line 41, strike "product of:" and insert "**hospital care for the indigent program property tax levy for taxes first due and payable in the preceding calendar year multiplied by the statewide average assessed value growth quotient, using all the county assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the tax levy under this subsection will be first due and payable.**".

Page 31, strike line 42.

Page 32, strike lines 1 through 15.

Page 33, between lines 9 and 10, begin a new paragraph and insert:
"SECTION 21. IC 27-8-5-16 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 16. Except as provided in sections 17 and 24 of this chapter, no policy of group accident and sickness insurance may be delivered or issued for delivery to a group that has a legal situs in Indiana unless it conforms to one (1) of the following descriptions:

(1) A policy issued to an employer or to the trustees of a fund established by an employer (which employer or trustees must be deemed the policyholder) to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(A) The employees eligible for insurance under the policy must be all of the employees of the employer, or all of any class or classes of employees. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, members, and partners of one (1) or more affiliated corporations, proprietorships, limited liability

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companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" includes elected or appointed officials.

(B) The premium for the policy must be paid either from the employer's funds, from funds contributed by the insured employees, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(2) A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two (2) or more creditors (which creditor, holding company, affiliate, trustee, trustees, or agent must be deemed the policyholder) to insure debtors of the creditor, or creditors, subject to the following requirements:

(A) The debtors eligible for insurance under the policy must be all of the debtors of the creditor or creditors, or all of any class or classes of debtors. The policy may provide that the term "debtors" includes:

(i) borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(ii) the debtors of one (1) or more subsidiary corporations; and

(iii) the debtors of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control.

(B) The premium for the policy must be paid either from the creditor's funds, from charges collected from the insured debtors, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be

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derived from the funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

(C) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(D) The amount of the insurance payable with respect to any indebtedness may not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments that are delinquent on the date the debtor becomes disabled as defined in the policy.

(E) The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Each payment under this clause must reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment, and any excess of the insurance must be payable to the insured or the estate of the insured.

(F) Notwithstanding clauses (A) through (E), insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan, and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

(3) A policy issued to a labor union or similar employee organization (which must be deemed to be the policyholder) to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(A) The members eligible for insurance under the policy must be all of the members of the union or organization, or all of any class or classes of members.

(B) The premium for the policy must be paid either from funds of the union or organization, from funds contributed by the insured members specifically for their insurance, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) A policy issued to a trust or to one (1) or more trustees of a

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fund established or adopted by two (2) or more employers, or by one (1) or more labor unions or similar employee organizations, or by one (1) or more employers and one (1) or more labor unions or similar employee organizations (which trust or trustees must be deemed the policyholder) to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(A) The persons eligible for insurance must be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes of employees or members. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(B) The premium for the policy must be paid from funds contributed by the employer or employers of the insured persons, by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and one (1) or more employers, unions, or similar employee organizations. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(5) A policy issued to an association or to a trust or to one (1) or more trustees of a fund established, created, or maintained for the benefit of members of one (1) or more associations. The association or associations must have at the outset a minimum of

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one hundred (100) persons, must have been organized and maintained in good faith for purposes other than that of obtaining insurance, must have been in active existence for at least one (1) year, and must have a constitution and bylaws that provide that the association or associations hold regular meetings not less than annually to further purposes of the members, that, except for credit unions, the association or associations collect dues or solicit contributions from members, and that the members have voting privileges and representation on the governing board and committees. The policy must be subject to the following requirements:

(A) The policy may insure members or employees of the association or associations, employees of members, one (1) or more of the preceding, or all of any class or classes of members, employees, or employees of members for the benefit of persons other than the employee's employer.

(B) The premium for the policy must be paid from funds contributed by the association or associations, by employer members, or by both, from funds contributed by the covered persons, or from both the covered persons and the association, associations, or employer members.

(C) Except as provided in clause (D), a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance must insure all eligible persons, except those who reject such coverage in writing.

(D) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(6) A policy issued to a credit union, or to one (1) or more trustees or an agent designated by two (2) or more credit unions (which credit union, trustee, trustees, or agent must be deemed the policyholder) to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee, trustees, or agent, or any of their officials, subject to the following requirements:

(A) The members eligible for insurance must be all of the members of the credit union or credit unions, or all of any class or classes of members.

(B) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in clause (C), must insure all eligible members.

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(C) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

(7) A policy issued to cover persons in a group specifically described by another law of Indiana as a group that may be covered for group life insurance. The provisions of the group life insurance law relating to eligibility and evidence of insurability apply to a group health policy to which this subdivision applies.

(8) A policy issued to a trustee or agent designated by two (2) or more small employers (as defined in IC 27-8-15-14) as determined by the commissioner under rules adopted under IC 4-22-2.

SECTION 22. IC 27-8-5-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 17. (a) A group accident and sickness insurance policy shall not be delivered or issued for delivery in Indiana to a group that is not described in section 16(1)(A), 16(2)(A), 16(3)(A), 16(4)(A), 16(5)(A), 16(6)(A), or 16(7), or **16(8)** of this chapter unless the commissioner finds that:

- (1) the issuance of the policy is not contrary to the best interest of the public;
- (2) the issuance of the policy would result in economies of acquisition or administration; and
- (3) the benefits of the policy are reasonable in relation to the premiums charged.

(b) Except as otherwise provided in this chapter, an insurer may exclude or limit the coverage under a policy described in subsection (a) on any person as to whom evidence of individual insurability is not satisfactory to the insurer."

Page 33, delete lines 36 through 39.

Page 35, between lines 28 and 29, begin a new paragraph and insert:

"SECTION 29. [EFFECTIVE UPON PASSAGE] (a) As used in this SECTION, "small employer" means any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

(b) The commissioner of the department of insurance and the office of the secretary of family and social services shall, not later

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than January 1, 2008, implement a program to allow two (2) or more small employers to join together to purchase health insurance, as described in IC 27-8-5-16(8), as amended by this act.

(c) The commissioner shall adopt rules under IC 4-22-2 necessary to implement this SECTION."

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass and be reassigned to the Senate Committee on Appropriations.

(Reference is to SB 503 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 9, Nays 0.

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